February 9, 2000

HEALTH and COMMUNITY SUPPORTS CONTRACT

between

DEPARTMENT OF HEALTH AND FAMILY SERVICES

and

_____ COUNTY

This is the base Family Care CMO Health and Community Supports contract for the year 2000. This contract is between the Department of Health and Family Services and the individual Care Management Organizations (CMOs).

The Health and Community Supports contract defines the program and operational requirements for a CMO, and includes the performance expectations and expected consumer outcomes.

This is the format with counties that will be serving all target populations. Revisions will be needed to tailor the document to each individual county's situation.

(date), 2000 – December 31, 2000

Health and Community Supports Contract

Table of Contents

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Department of Health and Family Services

and

_____ County

This contract is entered into for the period February 1, 2000 to December 1, 2000 by the Department of Health and Family Services, hereafter Department, whose principal business address is One West Wilson Street, P.O. Box 7805, Madison, Wisconsin, 53707-7850, and _____ County's Care Management Organization demonstration project, hereafter CMO, whose principal business address is _____.

Whereas, the Department wishes to purchase certain long term care and health care services, under the State Medicaid Plan approved by the Secretary of the U.S. Department of Health and Human Services pursuant to the Social Security Act, and is authorized to do so by Wisconsin law; and

The CMO is an organization which has been certified by the Department to make available to members, in consideration of periodic fixed payments, certain long term care and health care services;

Now, therefore, the Department and CMO agree as follows:

I. Consumer and Member Involvement

A. CMO Governing Board

The CMO shall have a governing board which meets the following specifications:

1. The board shall reflect the ethnic and economic diversity of the CMO service area.

2. At least one-fourth of the members of the board shall be older persons or persons with physical or developmental disabilities or their family members, guardians or other advocates who are representative of the CMO's members.

3. The CMO and Resource Center shall jointly develop a plan for the CMO's separation from the eligibility and enrollment functions of the Resource Center. The plan shall meet criteria established by the Department. The plan shall receive approval from the Department by July 1, 2000, and the plan shall be implemented by January 1, 2001.

[1] Definition of terms used in this contract are contained in Addendum I, page 87.

4. If the CMO is operating as a Family Care district, as described in s. 46.2895 Wis. Stats., it shall meet the requirements for governance in s. 46.2895 Wis. Stats.

B. Authorized Representatives

The CMO shall include the member's authorized representative (e.g. guardian, power of attorney for health care) in significant communications between the CMO and the member (e.g. member rights and responsibilities, development of Individual Service Plan), and in providing significant documents to the member (e.g. member handbook). The CMO shall allow the member's authorized representative to facilitate care or treatment decisions when the member is unable to do so.

C. Member Rights and Responsibilities Policies

The CMO shall actively promote the exercise of member rights and assure that its staff and CMO providers take into account those rights when providing services or otherwise interacting with members. The member rights and responsibilities, and related CMO policies shall be:

- Communicated to members in writing and verbally, and provided in the format necessary for members to understand;
- Communicated to CMO staff and CMO providers (the CMO will monitor the compliance of staff and providers with these policies);
- Incorporated into the CMO's internal review/evaluation.

D. Ethics Policies and Standards

The goal of the ethics functions is to help improve member outcomes by fostering respect for member's rights, and for maintaining each person's dignity and self-determination. The ethics policies shall be produced with the involvement of the CMO's staff, members, members' families and significant others, and CMO providers. These policies and standards shall be consistent with any policies and standards that are developed by the Department.

In order to form these policies, an ethics committee shall be formed and educated regarding such issues as: informed consent; codes of ethics that protect the integrity of decisions on member health care needs, regardless of how services are compensated; conflict resolution; the member's right to self-determination; human research; privacy; confidentiality; and end-of-life care. The ethics committee shall include at least one member of the CMO or one person who meets the functional eligibility for one of the target populations served by the CMO.

The minimum functions of the Ethics Committee are to:

- Establish standards on the issues such as those noted above in this subsection;
- Review and generate reports on existing ethics policies of the CMO in order to prevent conflicts with other providers and agencies;
- Be available to offer advice and guidance on individual cases;
- Investigate complaints and grievances regarding ethics violations; and

- Assist hospitals, providers of services in and outside of the LTC benefit package, long-term care facilities, and residential care facilities utilized by members in meeting the ethics standards of the CMO.

E. Member Safety and Risk

The CMO shall implement a policy that expressly prohibits all forms of abuse, neglect, exploitation, and mistreatment of members by CMO employees and providers. This policy shall include instruction in the proper reporting procedures when abuse or neglect is suspected.

The CMO shall develop specific written policies that address decision-making about care as it relates to members' safety and risk which address members with cognitive impairments. These policies shall be approved by the Department prior to implementation. The policies must include member's right to freedom from unnecessary physical or chemical restraint, and specify mechanisms to balance member needs for safety, protection, good physical health and freedom from accidents, with over-all quality of life and individual choice and freedom. CMO staff and other appropriate individuals shall be informed of these policies on an ongoing basis.

The CMO shall establish standards and methods for determining acceptable risk for members with cognitive impairments. The CMO shall have a mechanism to monitor, evaluate and improve its performance in the area of safety and risk issues. These mechanisms shall ensure there are individualized supports in place to facilitate a safe environment for each member. The CMO shall assure its performance is consistent with the understanding of the desired member outcomes and preferences. The CMO shall include family members and other informal supports when addressing safety concerns per the member's preference.

F. Performance Expectations

The CMO shall meet performance expectations outlined in Article XVII, *CMO Specific Contract Terms* (page 86).

The CMO shall also strive to achieve the consumer-centered outcomes described in Addendum II, *CMO Quality Indicators* (page 94). During the term of this contract, the CMO shall report data on these outcomes as specified in Addendum II *CMO Quality Indicators*, and the Department will use this data as well as data collected from other CMOs to set baseline expectations for performance. Future contracts will include specific performance expectations for these outcomes. (Future contracts meaning Health and Community Supports contracts after the original contract.)

II. CMO Functions: Enrollment and Disenrollment

A. Approval of Marketing/Outreach Plans and Materials

The CMO agrees to engage only in marketing/outreach activities that are pre-approved in writing, as follows:

- The CMO shall have a marketing/outreach plan approved in writing by the Department by the effective date of this contract;
- Annually, the CMO shall submit a marketing/outreach plan to the Department and receive written approval before future contracts will take effect;
- The CMO shall submit to the Department for approval all marketing/outreach materials, including mailings sent only to members, prior to disseminating the materials;
- The CMO agrees to comply with Ins. 6.07 and 3.27, Wis. Admin. Code.

The Department will review the marketing/outreach plan and materials as soon as possible, but within ten days of receipt. Marketing/outreach materials are deemed approved if there is no response from the Department within ten days. However, problems and errors subsequently identified by the Department must be corrected by the CMO when they are identified.

Approval of marketing/outreach plans and materials will be reviewed by the Department in a manner which does not unduly restrict or inhibit the CMO's marketing/outreach plans and materials, and which considers the entire content and use of the marketing/outreach materials and activities.

1. *Prohibited Practices.* The following marketing/outreach practices are prohibited:

    a. Practices that are discriminatory;
    b. Practices that seek to influence enrollment in conjunction with the sale of any other insurance product;
    c. Direct and indirect cold calls, either door-to-door or telephone;
    d. Offer of material or financial gain to potential members as an inducement to enroll;
    e. Activities and materials that could mislead, confuse or defraud consumers;
    f. Materials that contain false information;
    g. Practices that are reasonably expected to have the effect of denying or discouraging enrollment; and
    h. Marketing/outreach activities that have not received written approval from the Department.

2. *Marketing/Outreach Materials and Activities.* Marketing/outreach materials shall be distributed to all consumers eligible for the CMO in the service area. The Department will determine what marketing/outreach materials and marketing/outreach activities are subject to the requirements of this contract.

B. Member Handbook

A member handbook shall be reviewed and approved using an internal CMO advisory body (as defined under Article III(D)(1)(j), *Sensitivity to Population*, page 31).

1. *Required Information*. The handbook at a minimum will include information about:

a. Being a member of the CMO. This information shall include the nature of membership in a care management organization as compared to fee-for-service;

b. Obtaining assistance for members with cognitive impairments to review materials about membership in the CMO;

c. Location(s) of the CMO facility or facilities;

d. Hours of service;

e. Information on services in the LTC benefit package, including:
   - list of services in the LTC benefit package;
   - members' ability to select from the CMO's network of providers, and any restrictions on selecting providers;
   - ability to change providers;
   - any cost sharing related to these services;

f. Information on Medicaid covered services not in the LTC benefit package that remain fee for service and procedures for obtaining these services (for members who are Medicaid beneficiaries), including:
   - the list of these services;
   - how and where to obtain these services;
   - how transportation is provided;
   - any cost sharing related to these services;

g. Provider network listing which includes:
   - provider name (individual practitioner, or agency as appropriate);
   - provider location, and telephone number;
   - services furnished by the provider;
   - whether the provider is accepting new CMO members or not;
   - accessibility of the provider's premises (if the member will be receiving services at the provider's premises);

h. The right to receive services from culturally competent providers, and information about specific capacities of providers, such as languages spoken by staff, etc;

i. Information on the extent to which members may obtain services outside of the provider network;

j. Policies and procedures for advance authorization of services, and on the members' ability to obtain services necessary to achieve outcomes;

k. Policies on use of after hours services and obtaining services out of the CMO's service area;

l. Information on voluntary enrollment, voluntary disenrollment, and involuntary disenrollment;

m. Members' rights and responsibilities as defined by the Department;

n. Complaint and grievance process:
   - what constitutes a complaint, grievance, or fair hearing request;
   - how to file complaints, grievances and fair hearing requests, including timeframes and the member's ability to appear in person before the CMO personnel assigned to resolve complaints and grievances;
   - information about the availability of assistance with the complaint and grievance process, and fair hearings;
   - toll-free numbers that the member can use to register a complaint or submit a written grievance by telephone;
   - specific titles and telephone numbers of the CMO staff who have responsibility for the proper functioning of the process, and who have the authority to take or order corrective action;
   - assurance that filing a complaint or grievance or requesting a fair hearing process will not negatively impact the way the CMO, its providers, or the Department treat the member;
   - how to obtain services during the grievance and fair hearing processes;;

o. Procedure for members to have input on changes in the CMO's policies and services;

p. Notice of right to obtain information on results of member surveys; and

q. Information regarding estate recovery provisions applying to CMO membership.

2. *Initial Handbook.* The CMO shall have a member handbook approved by the Department before the effective date of this contract.

3. *Handbook Updates*. The CMO shall provide members periodic updates to the member handbook as needed to explain changes in the above areas. Such changes must be approved by the Department prior to distributing. Changes are considered approved if there is no response from the Department within 10 days. However, problems and errors subsequently identified by the Department shall be corrected by the CMO.

4. *Notices About Provider Changes.* Notices about changes in providers that are to be sent to members and shared with the Resource Center must be submitted to the Department for prior approval and will be approved as soon as possible, but within 30 days.

5. *Member Handbook Dissemination to Non-CMO Members.* The CMO shall provide the Resource Center with Department approved initial member handbook and

subsequent Department approved member handbooks for the purpose of dissemination to non-CMO members.

6. *Member Handbook Dissemination to CMO Members*. The CMO shall provide members a member handbook annually at a minimum.

C. Enrollment

The CMO shall comply with the following related to enrollment:

1. *Open Enrollment.* Conduct a continuous open enrollment period during which individuals shall be enrolled without regard to life situation (e.g., homelessness, need for supervision), health status/condition (e.g., degree of disability, having AIDS), or any other factor(s) provided the individual meets eligibility requirements as defined in Addendum I. *Definitions,* page 87. Enrollment shall occur in the order in which individuals are referred. Practices that are discriminatory and that could reasonably be expected to have the effect of denying or discouraging enrollment are prohibited.

2. *Voluntary Enrollment*. Enrollment in the CMO is voluntary.

3. *Enrollment While Eligibility is Pending*. The CMO shall have an MOU or other written agreement with the Resource Center that describes the circumstances in which the CMO will provide services to an individual who is functionally eligible but whose financial eligibility is pending, and that includes a process for the Resource Center to inform the individual that if he/she is determined not to be eligible, he/she will be liable for the cost of services provided by the CMO.

   The CMO will not receive a per member per month payment for an individual during the time eligibility is pending. If and when eligibility is established, the CMO will receive a per member per month payment retroactively to the date indicated as the "effective date of enrollment" on the Enrollment Request form, or the Family Care eligibility certification start date, whichever is later, up to a maximum of 90 days of serving the person while eligibility was pending.

   If the individual is determined not to be eligible, the CMO may bill that individual for the services the CMO has provided. The CMO shall pay providers for services which were provided and prior authorized by the CMO. The CMO shall not require providers to collect payment from the individual. The CMO shall refer non-eligible individuals to the Resource Center for counseling about long term care options.

   The timelines for completion of the comprehensive assessment and Individual Service Plan (ISP) shall be based on the date eligibility is established, not on the date of enrollment. The initial ISP shall be developed by the CMO and signed by the individual receiving services within five days of the date indicated as the "effective date of enrollment" on the Enrollment Request form.

D. ID Cards

The CMO may issue CMO ID cards, rely on the Family Care ID card, or both. The Family Care ID cards will signify enrollment in the specific CMO. The Department will inform Medicaid certified providers about the CMO initiative and the significance of the Family Care ID card. The Family Care ID card will always verify CMO enrollment, even where the CMO issues the CMO ID cards.

E. Disenrollment

The CMO shall comply with the following related to disenrollment:

1. *Voluntary Disenrollment*. All members shall have the right to disenroll from the CMO without cause at any time. If the member expresses a desire to disenroll from the CMO, the CMO shall make a referral to the Resource Center for choice counseling with the member. The Resource Center will notify the CMO about the final disenrollment decision. The CMO shall continue providing services until the disenrollment date.

2. The CMO shall not counsel or otherwise influence a member due to his/her life situation (e.g. homelessness, increased need for supervision) or condition (e.g. person with profound mental retardation, person with AIDS) in such a way as to encourage disenrollment.

3. *Ineligibility*. The member will be disenrolled if he/she loses his/her eligibility. Loss of eligibility occurs when:

    a. The member fails to meet functional or financial eligibility;
    b. The member initiates a move out of the CMO service area;
    c. The member fails to pay, or to make satisfactory arrangements to pay, any cost share amount due the CMO after a 30 day grace period;
    d. The member dies; or
    e. The member enters a public institution as defined in 42 CFR 435.1008 (e.g., state prison).

4. *Involuntary Disenrollment.* The CMO's intention to involuntarily disenroll a member shall be submitted to the Department for a decision and shall be processed in accordance with the H. *Department Complaint and Grievance Resolution Process* and/or I. *Fair Hearing Process* in Article IV, *Complaints and Grievance Procedures* (beginning on page 36). The only foreseeable reason to allow involuntary disenrollment would be if the member has physically assaulted a CMO employee or a CMO provider.

    When the CMO submits a request for disenrollment to the Department, the CMO shall also inform the member of the CMOs request for disenrollment and refer the member to the Resource Center for choice counseling and potential transition back to the fee for service system. The CMO shall continue to serve the member until the effective disenrollment date.

5. *Enrollment/Disenrollment Processing.* The process for enrollment/disenrollment from the CMO includes the following:

    a. The effective date of a voluntary enrollment shall be the date indicated on the Enrollment Request form as the "effective date of enrollment" or the Family Care eligibility certification start date, whichever is later.

    b. A voluntary disenrollment shall be effective on the date indicated on the disenrollment form as effective disenrollment date.

    c. In order to allow time for the member to grieve an involuntary disenrollment decision from the Department, the Department shall retain the Disenrollment Form for 14 days after the member has been notified by the Department before forwarding it to the Medicaid fiscal agent. If the member files a grievance of an involuntary disenrollment decision to the fair hearing process within 14 days, disenrollment shall be delayed until the grievance is resolved.

    d. If the member dies or the member initiates moving out of the service area, the date of disenrollment shall be the date of either event. The Department will recoup per member payments prorated on a daily basis and will continue to recoup any per member per month payments made for months subsequent to either event.

    e. If the member is disenrolled due to the loss of financial or functional eligibility, the date of disenrollment shall be the first day of the subsequent month.

    f. Until the date of disenrollment, members are required to continue using the CMO's providers for services in the LTC benefit package. The CMO shall continue to provide all needed services in the LTC benefit package until the date of disenrollment.

    g. To facilitate a member's reinstatement in the fee-for-service system (for members who are Medicaid beneficiaries), the CMO shall assist the member in obtaining necessary transitional care through appropriate referrals and by making member records available to new providers.

F. Enrollment/Disenrollment, Continued Enrollment and Re-Enrollment

The following provisions relate to enrollment, continued enrollment, disenrollment and re-enrollment practices:

1. The CMO shall permit the Department to monitor enrollment and disenrollment practices of the CMO under this contract. The CMO shall not discriminate in enrollment and disenrollment activities between individuals on the basis of life situation, condition or requirement for long term care or health care services.

2. The CMO shall not discriminate against a member based on income, pay status, or any other factor not applied equally to all members, and may not base involuntary disenrollment on such grounds.

3. If the member is disenrolled due to loss of functional or financial eligibility and re-establishes eligibility back to the date of disenrollment, and the CMO continues providing services during the interim, then the member will be re-enrolled into the CMO and the CMO shall be reimbursed for the period of disenrollment up to a maximum of 90 days.

4. In all cases of a member disenrolling and re-enrolling, the person must be processed through the enrollment process as a new referral.

5. In the case of voluntary disenrollment, the CMO shall allow an individual to re-enroll one time if the individual meets eligibility criteria. If the member voluntarily disenrolls for a second time, subsequent re-enrollments are at the discretion of the CMO. If the CMO chooses to consider subsequent re-enrollments, decisions shall be based on policies which do not discriminate based on cost, life situation, health status/condition.

6. Enrollment continues as long as desired by the eligible member regardless of changes in life situation or condition, until the member disenrolls.

7. The LTC Functional Screen and the Community Options Program Functional Screen will be conducted annually after the enrollment by the Resource Center, and the member must receive an “intermediate” or “comprehensive” rating from the Department for continued enrollment in the CMO.

8. The CMO may request the Resource Center to re-administer the LTC Functional Screen and the Community Options Program Functional Screen to re-evaluate the member’s “intermediate” or “comprehensive” rating if the member’s condition changes significantly.

9. If the CMO initiates a member’s move out of the service area, the CMO shall continue to receive the per member per month payment for that member and be responsible for payment for the member’s services in the LTC benefit package.

10. If the CMO initiates a member’s move out of the service area and into an area where another CMO is serving that target population, the CMO initiating the move shall be responsible for coordinating enrollment into the subsequent CMO, if the member so chooses.

G. Pre-Existing Conditions

The CMO shall assume responsibility for all covered long term care and medical conditions of each member as of the effective date of coverage under this contract.

III. CMO Functions: Services

Members shall be provided with high-quality long term care and health care services that are based on current standards of practice, that are from appropriate and qualified providers, that are fair and safe, that serve to maintain community connections, including work, and that are cost-effective.

The CMO will inform members of the full range of services in the LTC benefit package. The CMO will provide a range of services to meet the needs and outcomes of its members, as identified in the comprehensive assessment process.

The CMO is not restricted to providing only the services in the LTC benefit package listed below. In developing service plans in consultation with members, member's authorized representatives and informal supports, the CMO case management team may decide that other services, treatments or supports are more appropriate or likely to result in better outcomes than the services in the LTC benefit package (e.g., exceptional housing needs, acupuncture, membership in a fitness club). The per member per month payments made to the CMO will not be increased or decreased when additional or alternative services are provided.

Members shall receive services in the long term care benefit package where they live, including:

- Member's own home, including supported apartments;
- Alternative residential settings:
  - Residential Care Apartment Complex (RCAC);
  - Community Based Residential Facility (CBRF);
  - Adult and Family Homes; and
- Nursing Facilities or ICFs/MR.

The CMO shall provide support for self-directed care as described in this Article under A(6)(b), *Self-Directed Supports* (page 18).

A. Provision of Services in the LTC Benefit Package

1. *Services in the long term care benefit package for members at the comprehensive level*. The CMO shall promptly provide or arrange for the provision of all services in the LTC benefit package, consistent with Individual Service Plan (ISP) which include:

   - Adaptive Aids (general and vehicle) [1]
   - Adult Day Care [1]
   - Alcohol and Other Drug Abuse Day Treatment Services (in all settings) [2]
   - Alcohol and Other Drug Abuse Services, except those provided by a physician or on an inpatient basis [2]
   - Case Management (including Assessment and Case Planning) [1, 2]
   - Communication Aids/Interpreter Services [1]
   - Community Support Program [2]

- Counseling and Therapeutic Resources [1]
- Daily Living Skills Training [1]
- Day Services/Treatment [1]
- Durable Medical Equipment, except for hearing aids and prosthetics (in all settings)[2]
- Home Health [2]
- Home Modifications [1]
- Meals: home delivered [1] and congregate [3]
- Medical Supplies [2]
- Mental Health Day Treatment Services (in all settings) [2]
- Mental Health Services, except those provided by a physician or on an inpatient basis [2]
- Nursing Facility (all stays including Intermediate Care Facility for People with Mental Retardation (ICF/MR) and Institution for Mental Disease (IMD)[2]
- Nursing Services [2] (including respiratory care, intermittent and private duty nursing) and Nursing Services [1]
- Occupational Therapy (in all settings except for inpatient hospital) [2]
- Personal Care [2]
- Personal Emergency Response System Services [1]
- Physical Therapy (in all settings except for inpatient hospital) [2]
- Prevocational Services [1]
- Protective Payment/Guardianship Services [1]
- Residential Services: Residential Care Apartment Complex (RCAC) [1], Community Based Residential Facility (CBRF) [1], Adult Family Home [1]
- Respite Care (for care givers and members in non-institutional and institutional settings) [1]
- Specialized Medical Supplies [1]
- Speech and Language Pathology Services (in all settings except for inpatient hospital) [2]
- Supported Employment [1]
- Supportive Home Care [1]
- Transportation: Select Medicaid covered (i.e., Medicaid covered Transportation Services except Ambulance and transportation by common carrier[2]) and non-Medicaid covered [1]

[1] The services listed in this subsection with a (1) suffix are defined in Wisconsin's Health Care Finance Administration approved waivers: #0154.90.R1; #0229.90.04; #0297.02; and #0275.01 under s. 46.27 (11) Wis. Stats., and as otherwise specified in this contract.

[2] The services listed in this subsection with a (2) suffix are defined under s. 49.46(2), Wis. Stats., and HFS 107 Wis. Adm. Code; as further clarified in all Wisconsin Medicaid Program Provider Handbooks and Bulletins, CMO Contract Interpretation Bulletins (CIBs) and as otherwise specified in this contract.

[3] The services listed in this subsection with a (3) suffix are defined in the Department's Human Services Reporting System (HSRS) Manual and as otherwise specified in this contract.

2. *Services in the long term care benefit package for members at the intermediate level.* The CMO shall promptly provide or arrange for the provision of all services in the LTC benefit package, consistent with the Individual Service Plan, with a (2) suffix, with the following exception: members at the intermediate level, who are not residing in a nursing facility or ICF/MR at the time of enrollment, do not have access to long term care (i.e., care for longer than 90 days) in a nursing facility or ICF/MR. The CMO may also provide the other services listed in the LTC benefit package to members at the intermediate level. For members at the intermediate level, the CMO is not restricted to providing only services in the LTC benefit package with a (2) suffix. If the CMO decides other services are likely to result in better outcomes for the member, it may also provide the other services in the LTC benefit package as well as services, treatments or supports not listed in the LTC benefit package.

3. *Comparability of Services*. In order to ensure comparability of services, CMO members shall be entitled to all services available to participants in Wisconsin's HCFA approved waivers, which are:

   - Community Integration Program 1 (CIP 1), #0229.90.04
   - Community Supported Living Arrangement (CSLA), #0297.02
   - Community Options Program Waiver (COP-W), #0154.90.R1
   - Brain Injury Waiver (BIW), #0275.01

   The comparable s. 1915 (c) services are included in the list of services in the CMO benefit package, except for Self Directed Care (a benefit in the CIP 1 waiver), which the CMO shall make available to members as a type of care management.

4. *Changes in Mandated Services*. Changes to Medicaid covered services mandated by Federal or State law, and amendments to Wisconsin's HCFA approved waivers subsequent to the effective date of this contract will not alter the services in the LTC benefit package for the term of this contract, unless agreed to by mutual consent, or unless the change is necessary to continue to receive Federal funds or due to action of a court of law.

   a. *Per Member Per Month Payment Adjustment*. If any change in services in the LTC benefit package occur which are mandated by Federal or State law and incorporated into this contract, the Department shall adjust the per member per month rate accordingly.

   b. *Changes by Mutual Agreement.* The Department will give the CMO 30 days notice of any such change that reflects service increases, and the CMO may elect to accept or reject the service increases for the remainder of the term of this contract. The Department will give the CMO 60 days notice of any such change that reflects service decreases, with the right of the CMO to dispute the amount of

the decrease within that 60 day period. The CMO has the right to accept or reject service decreases for the remainder of the term of this contract.

c. *Date of Change Implementation.* The date of implementation of the change in coverage will coincide with the effective date of the increased or decreased funding. This section does not limit the Department's ability to modify this contract for changes made necessary by the State Budget.

d. *Notification to Members.* The CMO shall notify members within ten working days after the effective date of changes in the type of services in the LTC benefit package.

5. *Services Coordinated Through Medicaid Fee-For-Service.* For members who are Medicaid beneficiaries, the following Medicaid services remain fee-for-service. The CMO must arrange for services not covered in the LTC benefit package from other sources and instruct all members on where and how to obtain them, including how transportation is provided. The CMO shall coordinate these services for its members through the care management team:

- Alcohol and Other Drug Abuse Services provided by a physician or in an inpatient setting
- Audiology
- Chiropractic
- Crisis Intervention
- Dentistry
- Eyeglasses
- Family Planning Services
- Hearing Aids
- Hospice
- Hospital: Inpatient and Outpatient, including emergency room care (except as indicated in list of covered services beginning on page 14)
- Independent Nurse Practitioner Services
- Lab and X-Ray
- Mental Health Services provided by a physician or in an inpatient setting
- Optometry
- Pharmaceuticals
- Physician and Clinic Services (except as indicated in list of covered services beginning on page 14)
- Podiatry
- Prenatal Care Coordination
- Prosthetics
- School-Based Services
- Transportation: Ambulance and transportation by common carrier

6. *Care Management*
   Note: Care Management for private pay individuals is covered in (11) *Private Pay Case Management* (page 28) of this Article.

   a. *Member Participation.* To ensure optimum member participation in the Individual Service Plan (ISP) development and updating, and that members take an active role in decision-making regarding the long term care and health care services they need to live as independently as possible, the CMO shall provide the support requested or needed by members, their families or other representatives, when making informed health care decisions.

      Members shall receive clear explanations of (1) their condition, (2) risks involved in specific member preferences, (3) information on available treatment options or alternatives courses of care, (4) the benefits, drawbacks and likelihood of success of each option, and (5) the possible consequences of refusal to follow the recommended course of care.

      The CMO shall inform members of specific conditions that require follow-up, and if appropriate, provide training in self-care, including factors that hinder full participation with prescribed treatments or interventions included in the ISP.

   b. *Self-Directed Supports*. The CMO shall submit a plan for self-directed supports to the Department which receives approval prior to the effective date of this contract. The plan shall describe how the CMO will:
      - Inform all members of the self-directed support option;
      - Provide a mechanism by which a member may arrange for, manage and monitor the services in the LTC benefit package directly or with the assistance of another person chosen by the member;
      - Monitor the member's use of a fixed budget for purchase of services from any qualified provider;
      - Monitor the health and safety of the member;
      - Provide assistance in management of the member's fixed budget and services at a level tailored to the member's needs and desire for the assistance and;
      - Assess the self-directed support component. A report of this assessment shall be submitted to the Department 90 days before the expiration date of this contract.

   c. *Care Management Team Composition.* The member receives case management through a designated care management team which, at a minimum, consists of a social service coordinator and a registered nurse. The team utilizes appropriate additional specialized expertise for the initial comprehensive assessment, consultation, ongoing coordination efforts and other areas as needed. Except for existing employees holding a position comparable to a social service coordinator at the time of the initial contract effective date, the social service coordinator is required to have a minimum of a four-year bachelor's degree in the social services area (e.g. social work, rehabilitation psychology, etc.).

The service coordinator shall have knowledge of community alternatives for the target populations served by the CMO and the full range of long term care resources. Additionally, the service coordinator shall have specialized knowledge of the conditions of the target populations served by the CMO.

The CMO shall ensure ease of access for members to the care management team such as by designation of one member of the care management team as the member's primary care manager.

d. *Initial Individual Service Plan (ISP).* The CMO is responsible for providing needed services beginning on the date of enrollment. Upon enrollment, the care management team shall develop and implement an initial ISP, based on information received from the Resource Center and on the CMO's initial assessment of the member's needs. The initial ISP shall be developed by the CMO and signed by the member within five days of enrollment.

e. *Initial Comprehensive Assessment*. The member is central to the assessment process. The CMO shall, after each section of the assessment, document the member's choices and desired outcomes for each identified need. The care management team shall encourage the active involvement of any informal supports in the assessment as desired by the member. The care management team, member and informal supports shall jointly participate in completing a comprehensive assessment within 30 days of the enrollment date. If the CMO has been providing services to an individual while that individual's eligibility is pending, the comprehensive assessment shall be completed within 30 days of the date eligibility is established.

The assessment consists of at least the following areas without duplicating information already collected in the Long Term Care Functional Screen and the Community Options Program Functional Screen:

- Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) including:
  - All information collected in the screen, plus positioning, grooming, oral hygiene, laundry, chores;
  - Level of skill in performing the ADL or IADL;
  - Amount and frequency of help needed to perform the ADL or IADL;
  - Any assistive devices used, and the safety and adequacy of those devices.

- Physical Health including:
  - Current medications;
  - Medication history, if appropriate;
  - Pain assessment, treatment and therapies;
  - Diagnoses – including psychiatric diagnoses;
  - Alcohol and Other Drug Abuse (AODA) issues, including related medication use/misuse;

  - Systems review – vital signs, review of signs & symptoms (note complaints and problems):
  - Eye, ear, nose, throat, skin, allergies, gastrointestinal, cardiovascular, pulmonary, metabolic, musculoskelatal, hemotological;
  - Other issues related to health maintenance, e.g., stress management, lifestyle, access to primary care.

- Nutrition, including:
  - Height and weight, and any recent weight change;
  - Therapeutic diet and/or special approaches to nutrition;
  - Mouth, tooth, or denture problems, other oral or nutritional problems;
  - Food/diet preferences – e.g., kosher, vegetarian, herbal supplements, etc.

- Autonomy and Self-Determination including:
  - Degree to which person and/or their authorized representative prefers to run her/his own care plan, and what supports are needed to do so;
  - Personal preferences in regard to living situation, caregivers, daily routine, relationships, treatments and interventions, cultural and religious identity, etc.

- Communication, including:
  - Sensory status (vision, hearing, and touch);
  - Expressive and receptive mode of communication, including devices used;
  - Ability to be understood and to understand others.

- Mental health and cognition including:
  - Mood and behavior patterns that affect person's ability to manage life events;
  - Recent change in behavior or mood;
  - Recent changes in cognition;
  - Current treatments and past history of mood and behavior problems and/or treatments;
  - Issues related to death and dying, and need for grief counseling;
  - Ability to give informed consent (as defined in HFS 94.03);
  - Deficits in following directions, orientation, memory, judgement, problem solving, ability to plan.

- Presence of informal supports, including:
  - Quality and safety, adequacy, preferences, caregiver willingness, back-up plans.

- Member's rights and responsibilities, including:
  - Person's understanding of her/his rights, barriers to exercising those rights;
  - Other involved persons—e.g., guardian, power of attorney, etc.;
  - Determination of Least Restrictive Setting for individuals under guardianship.

- Community integration, including:

- Community participation and preferences;
- Relationships important to the person, present and past;
- Ways the person wants to participate socially, including re-linking to past ties;
- Transportation and escort needs.

- Safety, including:
  - Housing & home hazards, risk of falls and other harm;
  - Person's ability to recognize and respond to threats to safety, abuse and neglect;
  - Person's ability to respond effectively to problems;
  - Person's ability to follow through with health care needs (self-care);
  - Any challenging behaviors that pose a risk of danger to others, to self, or to property;
  - Person's ability to safely use substances, including safe use of flammables.

- Personal values, including:
  - A life review, which may include but is not limited to religion and/or faith preference, social history, education, work, family life, significant relationships, etc., or
  - Futures planning, including the person's hopes and vocational aspirations, and
  - Preferences for executing Advance Directives, such as durable power of attorney for health care (if not already completed).

- Education and vocational activities, including:
  - Educational level, current enrollment in educational settings;
  - Employment status and preferences, interest in employment, training, volunteering;
  - Barriers to employment;
  - Eligibility for funding programs other than Family Care;
  - Supports needed for work (e.g., funding, tutors, interpreter, childcare, job coach, etc.).

- Economic Resources, including:
  - Need for benefit counseling;
  - Need for energy assistance, housing, weatherization, veterans benefits, insurance policies;
  - Issues related to personal debt; and
  - Other legal issues.

  The results of the assessment are used by the care management team, member and his/her informal supports in identifying the service needs of the member and developing the Individual Service Plan (ISP).

f. *Initial Comprehensive Assessment Complaints and Grievances*. When the initial comprehensive assessment results in the member disagreeing with any of the assessment findings, the CMO shall discuss the issue with the member, and

follow procedures outlined in Article IV, *Complaints and Grievance Procedures* (page 32).

g. *Individual Service Plan (ISP) Development.* The care management team shall encourage the active involvement of the member's informal supports in the development of the ISP. The care management team, member and any informal supports shall jointly participate in the development of ISP based on the comprehensive assessment within 60 days of the enrollment date. If the CMO has been providing services to an individual while that individual's eligibility is pending, the ISP shall be completed within 60 days of the date eligibility is established.

For members with cognitive disabilities, the CMO shall ensure that family members, friends and other informal supports who know the member assist in conveying the member's preferences in the development of the ISP. In the development of the ISP, the CMO shall provide assistance as requested or needed to members in exercising their choices about where to live, with whom to live, work, daily routine, and services.

The ISP includes:

- Expected outcomes;
- Member's goals and preferences;
- Needs and preferences identified in the comprehensive assessment;
- Type of residential setting;
- Services or interventions to be provided, in order to meet the identified needs and honor the preferences identified in the comprehensive assessment;
- Coordination of services outside the LTC benefit package;
- The specific period of time covered by the ISP; and
- Party responsible for providing each service (including informal supports).

The CMO is responsible for furnishing services in the LTC benefit package based on the ISP, and coordinating all other services provided to the member from the date of enrollment. The ISP shall address comprehensive service needs regardless of whether the service is covered in the LTC benefit package or there is another source of payment (e.g., Medicare, Medicaid fee-for-service, private insurance).

In addition to informal supports, the care management team shall actively involve providers, agencies and others identified in the ISP in developing and revising the ISP. Involvement of participants shall be based on the preference of the member, and the parties' ability to contribute to the ISP regardless of provider type (e.g. primary care physician, psychiatrist).

The ISP shall be reviewed with and signed by the member, or the member's authorized representative as appropriate, to indicate his/her agreement with the ISP. The CMO shall provide the member with a copy of the signed ISP.

The CMO shall document in the member record instances when the ISP differs from the member's preference, and the reason for not meeting the member's preference. Regarding residence, the CMO shall attempt to utilize the least restrictive environment when that is the member's preference.

h. *Providing, Arranging and Coordinating Services.* The care management team is formally designated as being primarily responsible for coordinating the member's overall long term care and health care. In accordance with the ISP, the care management team shall authorize, provide, arrange for or coordinate services in the LTC benefit package, and coordinate all other services identified in the ISP, in a timely manner. The coordination of services includes ensuring that the informal support services are involved appropriately and in accordance with the member's preferences. The CMO shall ensure coordination of services internally and with services available from community organizations and other social programs.

   The CMO must meet and require its providers to: (1) meet State standards for timely access to care and member services, taking into account the urgency of need for services (these standards will be negotiated by the Department and the CMO either prior to effective date of contract or during the contract period); (2) establish mechanisms to ensure compliance with standards; (3) monitor continuously to determine compliance; and (4) take corrective action if there is failure to comply.

i. *Individual Service Plan Updates.* The member and care management team shall review and update the ISP periodically as the member's preferences, situation and condition changes or the ISP fails to accomplish the planned outcomes.

   When the ISP update results in a termination, suspension, or reduction of a service (including services authorized by a managed care organization the member was previously enrolled in or through Medicaid fee-for-service), the CMO shall discuss with the member the specific change in service and the reason(s) supporting the change in service, and follow procedures outlined in Article IV.D, *Notice of CMO Intention* (page 33).

j. *Individual Service Plan Complaints and Grievances.* When the ISP development or update results in denying, reducing, delaying or terminating a service (including services authorized by a managed care organization the member was previously enrolled in or through Medicaid fee-for-service), the CMO shall discuss with the member the specific denial or change in service, and the reasons supporting the denial or change in service, and follow procedures outlined in Article IV, *Complaints and Grievance Procedures* (page 32).

k. *Future Re-Assessments.* After the initial comprehensive assessment described above, the CMO conducts re-assessments based on:

   - Previous screens and assessments;

- Changes in the member's long term care and health care condition and situation; or
- Requests for an assessment by the member, the member's representative, the member's primary medical provider, or an agency involved with the member.

l. *Care Management Team and Member Contacts.* The care management team shall have sufficient contact and interaction with members to develop and maintain a relationship, be responsive to changing member needs and preferences, and monitor the appropriateness and quality of services. These contacts shall be recorded in the member record.

m. *Coordination of Services Not Included in the LTC Benefit Package.* The CMO shall build relationships with providers of services that remain fee-for-service. The CMO shall, at a minimum:

- Within 30 days of enrollment, document the member's primary care provider, specialty care provider(s), and psychiatrist (if applicable);

- Contact member's primary care provider and specialty care providers(s) to educate them about the CMO's procedures for accessing services in the LTC benefit package;

- Obtain the member's informed consent to receive and share appropriate health care information between and among all service providers;

- Provide member education in the effective use of primary care, specialty care and emergency services;

- Assist members to choose and secure providers of services not included in the LTC benefit package as needed;

- Develop a process to ensure providers of services outside the LTC benefit package (e.g. primary care physicians) can access services in the LTC benefit package (e.g. CMO referral and advance authorization processes);

- Intervene to improve access to providers of services not included in the LTC benefit package when necessary;

- Communicate with providers of services not included in the LTC benefit package when necessary to: (1) obtain or share information related to the member's physical and mental health, safety and participation in the community; (2) ensure services are appropriate and occur in a timely manner; and (3) coordinate services effectively, efficiently and without duplication;

- Provide feedback to provider when the member's needs are not being met by a particular plan of care;

- Regarding inpatient hospitalizations and stays in ICF/MRs and nursing homes, the CMO shall:

  - Assess the member's status within one week of admission;

  - Develop protocols and materials for transitions between care settings to avoid duplication of effort (e.g. assessments, etc.);

  - Share information and records relevant to the member's long term care and health care for the purposes of coordination and continuity of care;

  - Act as a liaison between family, facility and various health care providers and communicate member's needs and preferences;

  - Research the options available and explain to the member and his/her family the available options;

  - Review the facility's care plan for the member to ensure it integrates appropriate elements from the member's Individual Service Plan (ISP), and assess the facility's adherence to the care plan;

  - Consult with the facility about discharge planning including CMO involvement to: (1) authorize services in the LTC benefit package; (2) ensure use of CMO providers; (3) engage appropriate non-CMO providers when necessary; and (4) ensure successful transition to the subsequent setting;

  - Facilitate coverage between/among private insurance, Medicare and Medicaid, to assure seamless receipt of services by the member.

- Develop criteria and protocols to avoid member risk due to the prescription of medications and management of medications by more than one provider;

- Share, on an ongoing basis, clinical and Individual Service Plan (ISP) information as necessary to coordinate services in and outside of the LTC benefit package;

- Have policies for transfer of records to ensure continuity of care when members receive services not included in the LTC benefit package and when members receive services from more than one provider;

- Have policies and procedures to ensure coordination of emergency and urgent care services regarding the following areas:

- Process for the provider to notify the CMO and/or the care management team as soon as possible whenever a member has obtained urgent or emergency services, including methods for providers of such services to identify CMO members;

- Directions for how the member, others acting on behalf of the member and CMO providers can access the CMO's 24 hour on-call number, to obtain information about a member that may help in determining whether an emergency medical condition exists;

- Any procedures the provider must follow to contact the CMO before the provision of urgent or routine care;

- Procedure for creating and coordinating follow-up treatment plan;

- Policy for sharing of information and records between the CMO and emergency service provider;

- Process for arranging for appropriate hospital admissions;

- Policies regarding other continuity of care issues;

- Agreements, if any, between the CMO and the provider regarding indemnification, hold harmless, or any other deviation from malpractice or other legal liability which would attach to the CMO or emergency services provider in the absence of such an agreement.

n. *Transition of Care*. Within 10 working days of a member's request the CMO shall provide a clinical determination regarding the necessity of a member to continue receiving services from a non-CMO mental health or AODA provider. If the CMO determines that the member does not need to continue with the non-CMO provider, it shall ensure a successful transition to a CMO provider.

o. *Member Record.* Develop and maintain a record on each member as further discussed in Article VII.B, *Member Records* (page 59).

7. *Adult Protective Services.* For members in need of Adult Protective Services (APS), the CMO shall involve the entity or Department (which the County has arranged to administer APS) in the following capacities:

   a. The CMO shall invite an APS staff person to participate in the Individual Service Plan (ISP), ISP updates, comprehensive assessment and re-assessments; and

   b. The CMO shall invite an APS staff person to participate on the care management team to the extent that the APS staff person makes recommendations as necessary to fulfill their APS responsibilities.

If the County has made arrangements for the CMO to administer APS, the CMO shall assure that CMO staff with expertise in APS participate on the care management team in the capacities noted above for those members in need of APS.

8. *Payments for Services.* The CMO is responsible for payment of all services in the LTC benefit package provided to all members listed as ADDs or CONTINUES on either the Initial or Final Enrollment Reports (see Article VIII.E, *Disenrollment*, page 69) generated for the month of coverage. Additionally, the CMO agrees to provide, or authorize provision of, services in the LTC benefit package to all members with valid Family Care ID cards indicating CMO enrollment without regard to disputes about enrollment status and without regard to any other identification requirements. Any discrepancies between the cards and the reports will be reported to the Department for resolution. The CMO shall continue to provide and authorize provision of all services in the LTC benefit package until the discrepancy is resolved. This includes individuals who were PEND/CLOSE on the Initial Report and held a valid identification card indicating CMO enrollment, but did not appear as an ADD or CONTINUE on the Final Report.

9. *Necessity or Appropriateness of Services.* The CMO shall not deny services necessary to achieve outcomes as defined in Addendum I. *Definitions*, page 87. Disputes between the CMO and members about the necessity of services are resolved through the grievance process in Article IV, *Complaints and Grievance Procedures* (beginning on page 32). The determinations made through the grievance resolution process will be based on whether Medicaid would have covered that service on a fee-for-service basis, and whether the services meet the definition of "Services Necessary to Achieve Outcomes" in this contract.

10. *Billing Members.* The CMO, its providers and subcontractors will not bill a member for services in the LTC benefit package that received advanced authorization from the CMO and were provided during the member's enrollment period in the CMO, except as provided for in the 1915(c) waiver post-eligibility treatment of income. This provision pertains even if:

    a. The CMO becomes insolvent;
    b. The Department does not pay the CMO;
    c. The Department or the CMO does not pay the provider that furnishes the services under a subcontractual, referral or other arrangement; and
    d. Payment for services furnished under a subcontract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the CMO provided the service directly.

    In the event of the CMO's insolvency, the CMO shall not bill members for debts of the CMO.

    The CMO, its providers and subcontractors shall not bill a member for co-payments and/or premiums for services in the LTC benefit package under this contract and provided during the member's period of CMO enrollment. This provision shall

continue to be in effect if the CMO becomes insolvent. See Article II.C(3), *Enrollment* (page 10) for related requirements.

11. *Private Pay Care Management.* The CMO shall provide care management to individuals who are functionally eligible but not financially eligible to be members of the CMO.

    a. The CMO's rates for private pay case management shall either:
       - Be no higher than the Medicaid targeted case management rates which are in effect at the time of providing the service; or
       - Be approved by the Department.

    b. The CMO shall meet with the individual to achieve the following:
       - Fully review the specific aspects of care management the individual may purchase;
       - Clearly explain the cost of the service, and the billing and payment arrangements, including provisions for discontinuing service for failure to pay;
       - Clarify the specific care management tasks the individual agrees to purchase, the amount (e.g., number of hours) of care management that is being purchased, and who will be providing the care management;
       - Inform private pay individuals of their rights under Federal and State law (such as the Civil Rights Act of 1964, the Age Discrimination Act of 1975, and the Americans with Disabilities Act) and their rights to have access to their service records in accordance with applicable Federal and State laws;
       - Inform private pay individuals that they are not eligible to purchase services from CMO's contracted providers at rates the CMO has negotiated for services it purchases for enrollees;
       - Execute a written agreement containing the specific information described above. This agreement shall be signed by an authorized representative of the CMO and by the individual purchasing the service, or that person's authorized representative.

    c. The CMO's private pay care management service shall contain the following aspects at a minimum:
       - A comprehensive assessment of the person's long term care and health care needs;
       - Development of a care plan to meet the needs identified in the comprehensive assessment, as well as the person's identified outcomes and lifestyle preferences. The care plan in no way limits the person's ability to purchase services at his or her own expense from service providers;
       - Implementation and coordination of the care plan;
       - As appropriate, either assisting the person in filing complaints and grievances with non-CMO service providers, or referring the person for advocacy services.
       - Periodic reassessment, with appropriate updates to the care plan.

d. Individuals purchasing private pay care management may access the CMOs complaint and grievance process only insofar as those complaints or grievances pertain to the care management provided by the CMO. Complaints or grievances against the CMO may be filed with or appealed to the Department only insofar as those complaints or grievances pertain to the care management provided by the CMO. Complaints or grievances about other non-CMO services, which may be coordinated by the CMO, shall be filed with the service provider and if desired, with the appropriate regulatory agency.

B. 24 Hour Coverage

The CMO shall be responsible 24 hours each day, seven days a week for providing members with access to services in the LTC benefit package; coordination of services that remain Medicaid fee-for-service (for members who are Medicaid beneficiaries); and linkages to Adult Protective Services. The CMO shall:

1. Have one phone number members or individuals acting on behalf of members can call at any time to obtain advance authorization for services in the LTC benefit package. This number must provide access to individuals with authority to authorize the services in the LTC benefit package as appropriate. Individuals at this number must also have familiarity with the CMO and the CMO's provider network.

2. Respond to such calls within 30 minutes.

3. Be able to communicate with the caller in the language spoken by the caller.

4. Log these calls with time, date and any pertinent information related to person(s) involved, resolution and follow-up instructions.

5. Notify members and the Department of any changes of this one phone number within seven working days of change.

C. CMO Advocacy Services

1. The CMO shall designate a CMO employee to serve as a member advocate within the agency. The CMO member advocate shall report directly to top level management of the CMO, and shall perform the following functions at a minimum:

   a. Follow-up with new enrollees within 2 months after enrollment to answer questions and make certain members are aware of the advocacy services available to them;
   b. Assist individual members with issues and concerns that relate to the care management or the services provided through the CMO; and
   c. Assist in assuring quality services throughout the CMO.

D. Prevention and Wellness

Prevention and wellness shall be part of the normal course of communications with members, and the development of the member's Individual Service Plan (ISP). The CMO shall inform all members of contributions which they can make to the maintenance of their own health and the proper use of long term care and health care services. The activities and materials used in the prevention and wellness activities shall be accessible by the Department and the Health Care Financing Administration (HCFA). The CMO's plan for implementing the prevention and wellness program must be submitted to the Department and approved prior to the effective date of this contract (i.e., the first Health and Community Supports contract between the CMO and the Department). Upon contract renewal and at any time the Department determines there has been a significant change in the CMO's capacity to offer prevention and wellness services or in the CMO's projected membership, it may require the CMO to submit documentation to demonstrate its capacity to provide prevention and wellness services.

1. *The Prevention and Wellness Program.* The CMO's prevention and wellness program shall include the following components:

   a. *Program Coordination*. Designated staff are responsible for the coordination and delivery of services in the program.

   b. *Practice Guidelines*. Practice guidelines for prevention and wellness services that include member education, motivation and counseling about long term care and health care related services.

   c. *Measurement*. The capacity to collect, analyze and report data necessary to measure the performance of the prevention and wellness program. The reports based on this data shall be communicated to providers and members.

   d. *Program Resources*. Mechanisms for facilitating appropriate use of prevention and wellness services and educating members on health promotion.

   e. *Disease Prevention*. Information and policies on prevention of abuse and neglect, and the prevention and management of diseases which affect the populations served by the CMO. This includes specific information for persons who have or who are at risk of developing health problems that are likely to benefit from preventive practices. Hypertension and diabetes are examples of such health problems.

   f. *Independent Functioning.* Information and policies on maintaining and improving members' functional status, and the ability to perform ADLs and IADLs more independently, for the populations served by the CMO. This includes specific information for persons who have or who are at risk of impaired ability to function independently and are likely to benefit from preventive practices.

   g. *Outreach Strategies.* Outreach strategies for identifying and reaching members who are least likely to receive adequate preventive services.

h. *Special Health Issues*. The dissemination of information relevant to the membership, such as nutrition, AODA prevention, reducing self mutilation behaviors, exercise, skin integrity, self care training, and coping with dementia.

i. *General Information*. The dissemination of information on how to obtain the services of the prevention and wellness program (e.g. Resource Center, public health department etc.), as well as additional information on, and promotion of, other available prevention services offered outside of the CMO, such as special programs on women's health.

j. *Sensitivity to Population*. Long term care and health care related educational materials produced by the CMO shall be appropriate for its target population(s) and reflect sensitivity to the diverse cultures served. An internal advisory body composed of people meeting the functional eligibility requirements of the CMO, experts on long term care and health related subjects will establish a process to review and approve the health educational materials produced by the CMO. Also, if the CMO uses material produced by other entities, the CMO shall review these materials for appropriateness to its target population(s) and for sensitivity to the diverse cultures served. Finally, the CMO shall make all reasonable efforts to locate and use culturally appropriate long term care and health care-related materials.

E. Provision of Interpreters

The CMO shall provide interpreter services for members as necessary to ensure availability of effective communication regarding treatment, medical history, health education and information provided to members. Interpreter services are to accommodate foreign languages and impairments (e.g. sign language) of members. (For related information, refer to Article VII.D, *Accessibility of Language* (page 61). Furthermore, the CMO shall:

1. Provide for 24 hours a day, seven days a week access to interpreters conversant in languages spoken by members in the CMO. Also, upon a member or provider request for interpreter services in a specific situation where care is needed for a service in the LTC benefit package, the CMO shall make all reasonable efforts to provide an interpreter in time to assist adequately with the necessary care.

2. Use professional interpreters when needed where technical, medical, or treatment information is to be discussed, or where use of a family member or friend as interpreter is inappropriate.

3. Maintain a current list of interpreters who are on "on call" status to provide interpreter services.

4. Provision of interpreter services must be in compliance with Title VI of the Civil Rights Act of 1964.

F. Court Ordered Services

The CMO shall provide for court ordered treatment if it is a service in the LTC benefit package for which the CMO would be the primary payer and the member has been court ordered into placement or services through Chapter 51 or 55 of the Wis. Stats.

G. Advance Directives

The CMO shall comply with requirements of federal and state law with respect to advance directions (e.g., living wills, durable power of attorney for health care) and shall maintain written policies and procedures related to advance directives. The CMO shall:

1. *Written Information*. Provide written information at time of CMO enrollment to all adults receiving medical care through the CMO regarding:

    a. *Members' Rights.* The individual's rights under Wisconsin law (whether statutory or recognized by the courts of Wisconsin) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives, and

    b. *Policies*. The CMO's written policies respecting the implementation of such rights.

2. *Documentation*. Document in the member record whether or not the member has executed an advance directive.

3. *Fair Treatment.* The CMO shall not base the provision of care or otherwise discriminate against a member based on whether or not the member has executed an advance directive. This provision shall not be construed as requiring the provision of care which conflicts with an advance directive.

4. *Education*. Provide education for staff and the community on issues concerning advance directives.

The above provisions shall not be construed to prohibit the application of any Wisconsin law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider who, as a matter of conscience, cannot implement an advance directive.

IV. Complaints and Grievance Procedures

Members shall obtain a prompt resolution, through established procedures, of issues raised by the member, including complaints and grievances. Members shall have the option to be represented by an advocate, peer or representative in these processes.

A. Definitions

For the purposes of this contract, complaints and grievances have the following meanings:

Complaints are any oral or written communication made by or on behalf of a member to any CMO employee or a CMO provider or to the Department expressing dissatisfaction with any aspects of the CMO or CMO provider's operations, activities, or behaviors regardless of whether the communication requests any remedial action.

Grievances are written communication submitted by or on behalf of a member expressing dissatisfaction with any aspect of the CMO's or CMO provider's operations, activities, or behaviors that pertain to: 1) the availability, delivery or quality of long term care or health care services, including service authorization decisions that are adverse to the member; 2) payment, treatment or reimbursement of claims for long term care and health care services; or 3) issues unresolved through the complaint process.

B. Complaint and Grievance Process Responsibilities

The CMO shall have an internal complaint and grievance process with written policies and procedures, which are in accordance with this contract. The internal complaint and grievance process must receive Department approval prior to the effective date of this contract.

The CMO governing board shall approve and be responsible for the effective operation of the complaint and grievance process. This responsibility may be delegated to a committee of the CMO's senior management.

C. Complaints and Grievance Education

The CMO shall provide education to members on the complaint and grievance process within 60 days of enrollment. At a minimum, this education process shall include reviewing the CMO complaint and grievance process described in the member handbook. The CMO shall work proactively with the membership to encourage the use of the internal complaint and grievance process as the first step in the resolution of issues.

D. Notice of CMO Intention

1. *Notification to Member.* If the CMO intends to deny or limit a member's request for service; or to, reduce, delay, or terminate a current service, or deny payment for a service, the CMO shall give the member written notice at least ten days prior to the intended action. The CMO shall use a template notification letter for this purpose and shall receive approval from the Department prior to use. The notification letter shall include the following:

    a. The action the CMO intends to take;
    b. The reasons for the intended action;
    c. Any laws and rules that support the intended action;
    d. The member's rights, as well as how to file a complaint or grievance internally with the CMO, the Department, or through a fair hearing process;
    e. How to contact CMO personnel about the notice;
    f. The member's right to appear in person before the CMO personnel assigned to resolve grievances;

g. The fact that if a grievance is filed by the date of the intended action, or within 14 days of receipt of the written notice from the CMO (whichever is later), that *current* benefits will continue pending resolution of the grievance or issuance of a decision from the Department or the fair hearing process; and
h. How to obtain copies of member's records which include, but are not limited to, medical records.

E. Initiating a Complaint or Grievance

1. *Initiating a Complaint or Grievance*. The CMO shall identify a central point in the CMO to receive complaints and grievances and be responsible for routing them. However, complaints can be registered with any CMO employee. The CMO shall adequately staff the function of receiving and routing complaints and grievances. The CMO staff who are designated to be involved in the grievance process shall receive training in processing grievances. All CMO staff shall receive training in processing complaints.

2. *Acknowledgement*. Within five days of receiving a complaint or grievance, the CMO shall acknowledge to the member that the complaint or grievance has been received, and the expected date of a decision.

3. *Assistance to Members*. The CMO shall assist members with any steps necessary to resolve a complaint or grievance internally (e.g. assistance in writing, completing forms).

4. *Advocacy*. The CMO shall allow the member to involve anyone (e.g. significant other, professional advocate, or provider) in the complaint or grievance process. The CMO shall provide the member with information on how to contact advocacy agencies. The CMO shall also make arrangements with an entity independent of the CMO, at no cost to the CMO or the members, to assist members with a complaint or grievance.

   The CMO shall allow a provider to grieve on behalf of a member in instances of the CMO's decision to deny services or deny payment of services.

F. Standard Grievance Resolution

1. *Timeline.* The CMO shall operate a standard grievance resolution process to resolve grievances and notify the member of the decision as expeditiously as the member's situation and health condition requires, but no later than 20 days after the CMO receives the grievance. The timeline may be extended an additional 14 days if:

   a. The member requests the extension; or
   b. The Department approves the CMO's request for an extension based on a need for more information, and an explanation of how the extension is in the interest of the member.

2. *Involvement of Impartial Individuals.* In the resolution of grievances, the CMO shall involve individuals who have not been previously involved in review of, or decision-making regarding the circumstances of the grievance.

3. *Involvement of Appropriate Professional Expertise.* If the CMO's intention is to deny or limit a member's request for service; or to, reduce, delay, or terminate a current service, or deny payment for a service based on a lack of necessity, the process used to resolve the grievance shall involve a professional with appropriate expertise in the field that encompasses the member's long term care need.

4. *Involvement of Governing Board.* The governing board of the CMO shall review and resolve complaints and grievances. This function may be delegated in writing to a grievance committee.

5. *Involvement of Target Group.* The governing board/committee that reviews and resolves complaints and grievances must contain at least one member or one person who meets the functional eligibility for one of the target populations served by the CMO. This person must be free from conflict of interest regarding his or her participation in the governing board/committee.

6. *Investigation and Decision Making.* The CMO bases its decision regarding grievances on:

    a. The records related to the case; and
    b. The CMO's hearing process, which permit the member and the member's designated representative to appear before the CMO personnel responsible for resolving the grievance.

7. *Notification of Decision to Member.* The CMO shall give written notice of the decision to the member and any other affected parties. In addition to the decision reached, the notice shall include:

    a. The name of the contact person at the CMO for the grievance;

    b. The date the decision was reached;

    c. A summary of the steps taken on behalf of the member to resolve the issue;

    d. An explanation that if the member disagrees with the CMO's decision, he/she has a right to a Department grievance process, or a fair hearing process;

    e. How to file the grievance with the Department, and through the fair hearing process;

    f. An explanation that benefits will continue while the grievance is processed by the Department or the fair hearing process if the grievance is submitted by the date of the intended action, or within 14 days of receipt of the written notice from the

CMO (whichever is later), but that the member may be required to pay the cost of any services furnished during this time if the final decision is adverse to the member.

G. CMO Reversal of Decision

If the CMO reverses a prior decision to deny a service, through the standard grievance resolution process, the CMO shall authorize or provide the service as expeditiously as the member's situation or health condition requires, but no later than 30 days after the receipt of the reversal.

H. Department Complaint and Grievance Resolution Process

1. A member can submit a complaint or grievance directly to the Department before, during or after using the CMO complaint/grievance process. The Department shall acknowledge receipt of the complaint/grievance within five days of receiving it. This acknowledgement shall convey, at a minimum, that the complaint or grievance has been received and the expected date of a decision.

2. The Department will make a decision as expeditiously as the member's situation or health condition requires, but no later than 20 days after receipt of the complaint or grievance. This timeframe may be extended upon mutual agreement between the member and the Department. Any formal decision made by the Department under this section, shall be subject to member grievance rights as provided by State and Federal laws and rules. The Department will receive input from the member and the CMO in considering the complaint or grievance.

3. If the member disagrees with the Department's decision, it may be appealed through the fair hearing process for a decision.

4. If the CMO's grievance resolution decision to deny a service is reversed through the Department grievance resolution process, the CMO shall authorize or provide the service as expeditiously as the member's situation or health condition requires, but no later than 30 days after the receipt of the reversal.

I. Fair Hearing Process

1. A member can file a grievance directly to the fair hearing process for grievances of the following types of incidences before, during or after using the CMO grievance process:

    a. Failure to provide timely services and items that are included in the individual service plan;
    b. Reduction of services or items in the LTC benefit package;
    c. The Individual Service Plan (ISP) is unacceptable to the member because the ISP requires the member to live in place that is unacceptable to the member;
    d. The services or items identified in the ISP are insufficient to meet the member's needs, or are unnecessarily restrictive or unwanted by the member; or

e. Involuntary disenrollment

2. The member must file the grievance for a fair hearing within 45 days of one the types of incidences noted above, or receipt of written notice from the CMO or the Department (whichever is later).

3. A decision will be made through the fair hearing process as expeditiously as the member's situation or health condition requires. Any formal decision made through the fair hearing process under this section, shall be subject to member grievance rights as provided by State and Federal laws and rules. The fair hearing process will include receiving input from the member and the CMO in considering the grievance.

4. If the CMO's grievance resolution decision to deny a service is reversed through the fair hearing process, the CMO shall authorize or provide the service as expeditiously as the member's situation or health condition requires, but no later than 30 days after the receipt of the reversal.

J. Continuation of Benefits

1. The CMO shall continue the member's current benefits until the issuance of a grievance decision under the following circumstances:

   a. The member files a grievance by the date of the intended action, or within 14 days of receipt of the written notice from the CMO and/or the Department (whichever is later); and

   b. The current level of services was authorized by the CMO care management team; and

   c. The member requests the continuation.

2. If the requested services were not authorized by the CMO care management team, the CMO shall provide reasonable alternatives to the requested services, as appropriate, until the issuance of the grievance decision.

K. Documentation and Reporting

1. If the CMO makes a decision on a grievance that is entirely or partially adverse to the member, the CMO shall submit the decision and all supporting documentation to the Department as expeditiously as the member's situation and health condition requires, but no later than 20 days after the member receives notification of the decision from the standard grievance resolution process.

2. The CMO shall retain the documents related to each complaint and grievance for three years in a central location and make them accessible to the Department. If any action involving the documents or log is started before the expiration of the three year period (e.g. litigation, audit), the CMO shall retain the records until completion of the

action and resolution of issues which arise from it or until the end of the regular three year period (whichever is later).

3. Annually the CMO shall submit to the Department a complaint and grievance report consisting of a summary and a log, as follows:

   a. *Summary.* The summary shall be an analysis of the trends the CMO has experienced regarding types of issues complained and grieved about, and regarding specific providers that are the subject of complaints or grievances. If the summary reveals undesirable trends, the CMO shall conduct an in-depth review, report the results to the Department, and take appropriate corrective action.

   b. *Log.* The log shall include the following information about each complaint and grievance:

      - Whether it is a complaint or a grievance;
      - The nature of the complaint or grievance;
      - The timeline in which it was resolved;
      - The decision;
      - Whether the grievance was resolved to the satisfaction of the member; and
      - Whether a disenrollment occurred during the course of a complaint or grievance, and if so, the reason for the disenrollment;

   The documentation and reporting required in this Article regarding complaints and grievances provide the basis for monitoring by the CMO and the Department.

4. The requirements of this section shall be in compliance with Article VII.B, *Member Records* (page 59), and Article XIV, *Confidentiality of Records* (page 82).

L. Information to Providers

At the time of subcontracting, the CMO shall furnish providers with information regarding the grievance process as specified in Article II.B (1)(n), *Complaint and Grievance Process* (page 9).

V. CMO Functions: Service Providers

A. Choice of Providers and Care Management Teams

1. The CMO shall inform members about the full range of provider choice available to them, including free choice of medical and other providers that remain fee-for-service.

2. *Member Choice of Providers.* For services in the LTC benefit package that involve providing intimate personal needs or when a provider frequently comes into the member's home, the CMO shall, upon request of the member, purchase services from any qualified provider who will accept and meet the provisions of the CMO's

subcontract for subcontractors of the same service. These services include, but are not limited to, personal care, home health, private duty nursing, supportive home care and chore service. The provisions of subcontracts for services mentioned in this paragraph shall focus on quality and cost effectiveness, and not be constructed in such a way so as to limit the network of providers.

3. *Non-CMO Providers.* The CMO shall maintain a process to consider a member's request for a non-CMO provider, which is a provider who does not have an agreement with the CMO for providing services in the LTC benefit package to members. The CMO shall arrange for services with non-CMO providers if the member's request is authorized by the CMO. Instances where the member's request for a non-CMO provider is warranted include: (1) when the CMO does not have the capacity to meet the need; (2) when the CMO does not have the specialized expertise, specialized knowledge or appropriate cultural diversity in its network of providers; (3) when the CMO can not meet the need on a timely basis; or (4) when transportation or physical access to the CMO providers causes an undue hardship to the member.

4. *Member Choice of Care Management Teams.* The CMO shall allow a member to change care management teams up to two times per calendar year if the CMO has additional care management teams to offer the member.

B. Provider Network and Subcontracts

The term "subcontract" in this section refers to the definition provided in Addendum I, *Definitions* (page 87). The term does not apply to supplemental contracts between the CMO and the Department. The Department shall have sole authority to determine the conditions and terms of supplemental contracts between the CMO and the Department.

1. *Administrative Costs.* In establishing provider and management subcontracts, the CMO shall seek to maximize the use of available resources and control costs.

2. *Subcontractor Audits.* CMO providers may be eligible for waivers of the audit requirements under s. 46.036(4) Wi. Stats., based on a risk assessment to be performed by the CMO, subject to approval by the Department.

3. *Department's Discretion*. The Department may approve, approve with modification, or deny subcontracts under this contract at its sole discretion. The Department may, at its sole discretion and without the need to demonstrate cause, impose such conditions or limitations on its approval of a subcontract as it deems appropriate. The Department may consider such factors as it deems appropriate to protect the interests of the State and members, including but not limited to, the proposed subcontractor's past performance.

4. *Legal Liability.* The CMO shall assure that all subcontracts shall not terminate legal liability of the CMO under this contract. The CMO may subcontract for any or all functions covered by this contract, subject to the requirements of this contract.

5. *Deadlines*. If the Department requires the CMO to find a new subcontractor, the CMO shall secure a new subcontractor in 120 days, and 60 days to implement any other change required by the Department. The Department will acknowledge the approval or disapproval of a subcontract within 14 days after its receipt from the CMO. Lack of such acknowledgment within 14 days shall constitute approval.

6. *Member Provider Communications*. The CMO may not prohibit or otherwise restrict a provider from advising members about the long term care and health care status of the member, or medical care and treatment for the member's condition or disease regardless of whether the service are services in or outside of the LTC benefit package if the provider is acting under the lawful scope of practice.

7. *Before Effective Date of Contract*. By the effective date of this contract, the CMO shall have submitted its subcontracts and obtained Department approval by one of two means: 1) the CMO submits each subcontract to the Department for review and approval or disapproval, or 2) the CMO submits template language to the Department planned for use in the CMO's subcontracts for Department review and approval or disapproval. After the CMO receives approval on templates, the CMO sends the Department an affidavit stating the approved templates were used for each subcontractor. For each subcontractor the affidavit includes the subcontractor's name, service type and date of subcontract expiration. Any disapproval of subcontracts may result in the application by the Department of remedies pursuant to Article XI, *Remedies for Violation, Breach or Non-Performance of Contract* (page 76).

   By the effective date of this contract, the CMO shall demonstrate to the Department an adequate capacity to provide the projected membership in the service area with: the appropriate range of services; access to prevention and wellness services; a sufficient number, mix and geographic distribution of providers of services; specialized expertise with the target population(s) served by the CMO; culturally competent providers (see F. *Cultural Competency*, page 51); and services that are physically accessible and available on a timely basis.

   The CMO shall develop standards for geographic access and timeliness of access to services in the LTC benefit package and member services that meet or exceed such standards as may be established by HCFA or the Department.

   Evidence of adequate capacity to serve the membership is as follows:

   a. For services in the LTC benefit package that are defined under s. 49.46(2), Wis. Stats., and HFS 107 Wis. Adm. Code evidence of adequate capacity to serve the membership is by subcontractual relationships with providers or ability to provide the service directly.

   b. For the remaining services in the LTC benefit package evidence of adequate capacity to serve the membership is by subcontractual relationships with providers, ability to provide the service directly, or an Adequate Service Coverage

Plan approved by the Department. This plan shall detail the CMO's ability to provide adequate coverage of services to the membership.

8. *After Effective Date of Contract*. The Department may review any and all subcontracts at any time.

    a. *Affidavit of Subcontracts.* An affidavit of subcontracts shall be submitted and receive Department approval before renewing this contract, and at any time the Department determines there has been a significant change in the CMO's capacity to offer services in the LTC benefit package or in the CMO's projected membership. The affidavit shall include:

        - A statement that all of the required provisions of subcontracts are met (see *Requirements for Subcontracts* below);
        - A listing of the provider network (which consists of provider/agency name, location, services furnished by provider, and whether the provider is accepting new CMO members or not); and
        - Expiration date of all subcontracts.

    b. *Adequate Service Coverage Plan*. This plan, described in (8)(b) of this section shall be submitted to the Department and receive approval prior to the effective date of this contract and before renewing the contract.

    c. *Notices About Provider Changes*. Notices about changes in providers that are to be sent to members must be submitted to the Department for approval and will be approved as soon as possible, but within 30 days.

    d. *Information to Members*. Upon the request of members, the CMO shall make available information about the identity, locations, qualifications, and availability of services in the LTC benefit package from providers that participate in the CMO.

    e. *Timeliness and Quality of Services.* The CMO shall furnish services in the LTC benefit package promptly and without compromising quality of care.

    f. *Monitoring Access to Services.* The CMO shall continuously monitor the extent to which it maintains an adequate capacity to provide the membership with the appropriate range of services, access to prevention and wellness services, a sufficient number, mix and geographic distribution of subcontractors of services, specialized expertise with the target population(s) served by the CMO before the effective date of the contract, culturally competent providers, (see F, *Cultural Competency*, page 51), and accessible services (meaning physically accessible, and available on a timely basis). The CMO shall take corrective action on deficiencies in any of these areas as necessary.

9. *Requirements for Subcontracts.* All subcontracts shall be in writing, shall include the provisions of this subsection, and shall include any general requirements of this

contract that are appropriate to the service. The subcontractor must agree to abide by all applicable provisions of this contract. Subcontractor compliance with this contract specifically includes, but is not limited to, the following requirements (except for specific areas that are inapplicable in a specific subcontract):

a. *Parties of the Subcontract.* The CMO and subcontractor entering into the agreement are clearly defined.

b. *Definitions.* Subcontract defines the terms that may be interpreted in ways other than what the CMO intends.

c. *Services.* Subcontract clearly delineates the services being provided, arranged, or coordinated by the subcontractor.

d. *Compensation.* Subcontract specifies rates for purchasing services from the provider. Subcontract specifies payment arrangements in accordance with Article V.C(3), *Thirty Day Payment Requirement* (page 47).

e. *Term and Termination.* Subcontract specifies the start and end date of the subcontract and the means to renew, terminate and renegotiate. Subcontract specifies the CMO's ability to terminate and suspend the subcontract based on quality deficiencies and a process for the provider appealing the termination or suspension decision.

f. *Legal Liability.* Subcontract agrees that no terms of the subcontract are valid which terminate legal liability of the CMO in accordance with Article VII.G, *Compliance with Applicable Law* (page 65).

g. *QA/QI Programs*. Subcontractor agrees to participate in and contribute required data to the CMO's QA/QI programs as required in Article VI, *CMO Functions: Quality Assurance/Quality Improvement* (page 52).

h. *Utilization Data*. Subcontractor agrees to submit CMO utilization data in the format specified by the CMO, so the CMO can meet the Department specifications required by Article X, *Reports and Data* (page 72), and Addendum IV, *Reporting* (page 103).

i. *Non-Discrimination*. Subcontractor agrees to comply with all non-discrimination requirements in Article VII.E, *Civil Rights* (page 62).

j. *Insurance and Indemnification.* Subcontractor attests to carrying the appropriate insurance and indemnification.

k. *Independent Contractor.* Subcontract recognizes the agreement is between two separate parties that are independently and freely entering into a subcontract.

l. *Notices.* Subcontract specifies a means and a contact person for each party for purposes related to the subcontract (e.g. interpretations, subcontract termination).

m. *Access to Premises*. Subcontractor agrees to provide representatives of the CMO, as well as duly authorized agents or representatives of the Department and the Federal Department of Health and Human Services, access to its premises, and/or medical records in accordance with Article VII.J, *Access to Premises and Information* (page 67).

n. *Certification and Licensure*. CMO subcontractors and health care facilities agree to provide licensure, certification and accreditation status upon request of the CMO. Health professions which are certified by Medicaid (e.g. physical therapy) agree to provide information about their education, Board certification and recertification upon request of the CMO. Subcontractor agrees to notify the CMO of changes in licensure.

o. *Records.* Subcontractor agrees to comply with all applicable Federal and State record retention requirements.

p. *Member Records.* Subcontractor agrees to the requirements for maintenance and transfer of records stipulated in Article VII.B, *Member Records* (page 59). Subcontractor agrees to make records available to members and his/her authorized representatives within ten working days of the record request.

Subcontractors must forward records to the CMO pursuant to grievances within 15 working days of the CMO's request. If the subcontractor does not meet the 15-day requirement, the subcontractor must explain why and indicate when the records will be provided.

Subcontractor agrees otherwise to preserve the full confidentiality of records in accordance with Article XIV, *Confidentiality of Records* (page 82).

q. *OSHA Requirement.* Subcontractor attests to meeting applicable OSHA requirements.

r. *Access to Services.* Subcontractor agrees not to create barriers to access to care by imposing requirements on members that are inconsistent with the provision of services necessary to achieve outcomes that are in the LTC benefit package (e.g., Third Party Liability recovery procedures that delay or prevent care).

s. *Authorization for Providing Services*. Subcontract delineates the process the provider follows to receive authorization for providing services in the LTC benefit package to members. Subcontractor agrees to clearly specify authorization requirements to its providers and in any sub-subcontracts.

t. *Billing*. Subcontractor agrees not to bill a member for services in the LTC benefit package that received advance authorization from the CMO and were provided

during the member's period of CMO enrollment. This provision shall continue to be in effect even if the CMO becomes insolvent.

u. *Appeals.* Subcontractor agrees to abide by the terms of Article V.C(5), *Appeals to the CMO and Department for Payment/Denial of Providers Claims* (page 48).

v. *Complaints and Grievances.* Subcontractor agrees to comply with the CMO's efforts regarding member's complaints and grievances that may involve the subcontractor.

10. *Additional Requirements for Management Subcontracts.* Management subcontracts for administrative services will be subject to additional review to assure that rates are reasonable:

a. *Services and Compensation*. Subcontracts for CMO administrative services must clearly describe the services to be provided and the compensation to be paid.

b. *Bonuses, Profit-Sharing*. Any potential bonus, profit-sharing, or other compensation not directly related to costs of providing goods and services to the CMO, shall be identified and clearly defined in terms of potential magnitude and expected magnitude during the subcontract period.

c. *Reasonableness.* Any such bonus or profit-sharing shall be reasonable compared to services performed. The CMO shall document reasonableness.

d. *Limits.* A maximum dollar amount for such bonus or profit-sharing shall be specified for the subcontract period.

11. *Ownership.* The CMO agrees to submit to the Department within 30 days of the effective data of the contract, full and complete information as to the identity of each person or corporation with an ownership or control interest in the CMO, or any subcontractor in which the CMO has a 5% or more ownership interest.

a. *Definition of "Person with an Ownership or Control Interest."* A "person with an ownership or control interest" means a person or corporation that:

- Owns, directly or indirectly, 5% or more of the CMO's capital or stock or receives 5% or more of its profits. The percentage of direct ownership or control is calculated by multiplying the percent of interest which a person owns by the percent of the CMO's assets used to secure the obligation. Thus, if a person owns 10% of a note secured by 60% of the CMO's assets, the person owns 6% of the CMO. The percentage of indirect ownership or control is calculated by multiplying the percentages of ownership in each organization. Thus, if a person owns 10% of the stock in a corporation which owns 80% of the stock of the CMO, the person owns 8% of the CMO.

- Has an interest in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the CMO or by its property or assets, and that interest is equal to or exceeds 5% of the total property and assets of the CMO; or;

- Is an officer or director of the CMO (if it is organized as a corporation) or is a partner in the CMO (if it is organized as a partnership).

b. *Information to be Disclosed.* The following information must be disclosed:

- The name and address of each person with an ownership or controlling interest of 5% or more in the CMO or in any subcontractor in which the CMO has direct or indirect ownership of 5% or more;

- A statement as to whether any of the persons with ownership or control interest are related to any other of the persons with ownership or control interest as spouse, parent, child, or sibling; and

- The name of any other organization in which the person also has ownership or control interest. This is required to the extent that the CMO can obtain this information by requesting it in writing. The CMO shall keep copies of all of these requests and responses to them, make them available upon request, and advise the Department when there is no response to a request.

c. *Potential Sources of Disclosure Information.* This information may already have been reported on Form HCFA-855, "Disclosure of Ownership and Control Interest Statement." Form HCFA-855 is likely to have been completed in two different cases. First, if the CMO is Federally qualified and has a Medicare contract, it is required to file Form HCFA-855 with HCFA within 120 days of the CMO's fiscal year end. Secondly, if the CMO is owned by or has subcontracts with Medicaid providers which are reviewed by the State survey agency, these providers may have completed Form HCFA-855 as part of the survey process. If Form HCFA-855 has not been completed, the CMO may supply the ownership and control information on a separate report or submit reports filed with the State's insurance or health regulators as long as these reports provide the necessary information for the prior 12-month period.

As directed by the HCFA Regional Office (RO), this Department must provide documentation of this disclosure information as part of the prior approval process for contracts. This documentation must be submitted to the Department and the RO prior to each contract period. If the CMO has not supplied the information that must be disclosed, a contract with the CMO is not considered approvable for this period of time and no full Federal participation is available for the period of time preceding the disclosure.

d. *Prohibited Providers.* The CMO may not knowingly have a person who is debarred, suspended, or otherwise excluded from participating in procurement

activities under the Federal Acquisition Regulation or from participating in non-procurement activities as a director, officer, partners, or person with a beneficial ownership of more than 5% of the entity's equity, or have an employment, consulting, or other agreement for the provision of items and services that are significant and material to the CMO's obligations under this contract.

12. *Business Transactions.* The CMO shall disclose to the Department information on certain types of transactions they have with a "party in interest" as defined in the Public Health Service Act. (See Sections 1903(m)(2)(A)(viii) and 1903(m)(4) of the Act.) Definition of a Party in Interest. As defined in Section 1318(b) of the Public Health Service Act, a party in interest is:

    a. Any director, officer, partner, or employee responsible for management or administration of a CMO; any person who is directly or indirectly the beneficial owner of more than 5% of the equity of the CMO; any person who is the beneficial owner of more than 5% of the CMO; or, in the case of a CMO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law; or

    b. Any organization in which a person described in subsection (a) is director, officer or partner; has directly or indirectly a beneficial interest of more than 5% of the equity of the CMO; or has a mortgage, deed of trust, note, or other interest valuing more than 5% of the assets of the CMO;

    c. Any person directly or indirectly controlling, controlled by, or under common control with the CMO; or

    d. Any spouse, child, or parent of an individual described directly above in a, b or c.

13. *Types of Transactions Which Must Be Disclosed*. Business transactions which must be disclosed include:

    a. Any sale, exchange or lease of any property between the CMO and a party in interest;

    b. Any lending of money or other extension of credit between the CMO and a party in interest; and

    c. Any furnishing for consideration of goods, services (including management services) or facilities between the CMO and the party in interest. This does not include salaries paid to employees for services provided in the normal course of his/her employment.

    The information which must be disclosed in the transactions listed directly above between the CMO and a party in interest includes:

    - The name of the party in interest for each transaction;

- A description of each transaction and the quantity or units involved;
- The accrued dollar value of each transaction during the fiscal year; and
- Justification of the reasonableness of each transaction.

If this contract is being renewed or extended, the CMO shall disclose information on these business transactions which occurred during the prior contract period. If the contract is an original contract with the Department, but the CMO has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period must be disclosed. The business transactions which must be reported are not limited to transactions related to serving the Medicaid enrollment. All of these CMO business transactions must be reported.

The CMO shall notify the Department within seven days of any notice given by the CMO to a subcontractor, or any notice given to the CMO from a subcontractor, of a subcontract termination, a pending subcontract termination, or a pending modification in subcontract terms, that could reduce member access to care.

If the Department determines that a pending subcontract termination or pending modification in subcontract terms will jeopardize member access to care, then the Department may invoke the remedies provided for in Article XI, *Remedies for Violation, Breach, or Non-Performance of Contract* (page 76). These remedies include contract termination (with notice to the CMO and an opportunity to correct provided for), and suspension of new enrollment.

The CMO shall submit MOUs referred to in this contract to the Department upon the Department's request.

The CMO shall submit copies of changes in MOUs to the Department within 15 days of the effective date of the contract.

C. Payment to Providers

1. In subcontracting with and paying providers, the CMO is not subject to s. 46.036 (3) and (5m), Wis. Stats., which refer to allowable costs. The CMO may expend funds from the per member per month payment rates on a subcapitated basis.

2. *Medicaid Rates.* The CMO shall not pay its providers more than the Medicaid fee-for-service rates for Medicaid covered services in the LTC benefit package unless the Department approves a higher level of payment. The Department will base the approval on whether the service will result in added quality or value, or if the availability of service providers at the Medicaid fee-for-service rate is not sufficient.

3. *Thirty Day Payment Requirement.* The CMO shall pay at least 90% of claims from subcontractors for services in the LTC benefit package that receive advance authorization from the CMO within 30 days of receipt of bill, and 99% within 90 days, except to the extent subcontractors have agreed to later payment. The CMO

agrees not to delay payment to subcontractors pending subcontractor collection of third party liability (TPL) unless the CMO has an agreement with their subcontractor to collect TPL.

4. *Claims Retrieval System.* The CMO shall maintain a claims retrieval system that can, on request, identify date service was received, action taken on all provider claims (i.e., paid, denied, other), and when action was taken. The CMO shall date stamp all provider claims upon receipt.

5. *Appeals to the CMO and Department for Payment/Denial of Providers Claims.* The CMO shall:

   a. Provide the name of the person and/or function at the CMO to whom provider appeals should be submitted.

   b. Provide written notification to providers of the CMO payment/denial determinations. These notifications will include:

      - A specific explanation of the payment amount or a specific reason for the payment denial;

      - A statement regarding the provider's rights and responsibilities in appealing the CMO's initial determination by submitting a separate letter or form which:
        - Is clearly marked "appeal";
        - Contains the provider's name, date of service, date of billing, date of rejection, and reason(s) claim merits reconsideration for each appeal; and
        - Is submitted to the person and/or function at the CMO that handles Provider Appeals within 60 days of the initial denial or partial payment.

      - A statement advising the provider of the provider's right to appeal to the Department if the CMO fails to respond to the appeal (as indicated directly above) within 45 days, or if the provider is not satisfied with the CMO's response to the request for reconsideration. All appeals to the Department must be submitted in writing within 60 days of the CMO's final decision.

   c. Accept written appeals from providers who disagree with the CMO's payment/denial determination, if the provider submits the dispute in writing within 60 days of the initial payment/denial notice. The CMO has 45 days from the date of receipt of the request for reconsideration to respond in writing to the provider. If the CMO fails to respond within that time frame, or if the provider is not satisfied with the CMO's response, the provider may seek a final determination from the Department.

   d. Accept the Department's determinations regarding appeals of disputed claims. In cases where there is a dispute about the CMO's payment/denial determination and the provider has requested a reconsideration by the CMO according to the terms described above, the Department will hear appeals and make final determinations.

These determinations may include the override of the CMO's time limit for submission of claims in exceptional cases. The Department will not exercise its authority in this regard unreasonably. The Department will accept written comments from all parties to the dispute prior to making the decision. Appeals must be submitted to the Department within 60 days of the date of written notification of the CMO's final decision resulting from a request for reconsideration. The Department has 45 days from the date of receipt of all written comments to respond to these appeals. The CMO shall pay provider(s) within 45 days of receipt of the Department's final determination.

D. Employment Practices

1. The CMO shall set competency standards for CMO staff providing services in the LTC benefit package. The CMO shall provide or arrange for training for such CMO employees to meet competencies. The CMO shall establish a system for monitoring CMO staff providing services in the LTC benefit package to assure for the provision of quality services. Refer to Article VI.C, *Provider Selection and Retention* (page 55) for related employee standards.

2. A person in the member's family (except for the spouse of a member) shall be paid by the CMO for services if all of the following apply:

    a. The service is authorized by the care management team.
    b. The member's preference is for the family member to provide the service.
    c. The family member meets the CMO's standards for its subcontractors or employees providing the same service.
    d. The family member will either:
        - Provide an amount of service that exceeds normal family care giving responsibilities for a person in a similar family relationship who does not have a disability, or
        - Find it necessary to forego paid employment in order to provide the service and is not receiving a pension (including Social Security retirement benefits).

3. If the CMO is the employer of attendants for the purposes of supportive home care, personal care or home health aid services the following conditions shall be met:

    a. Members choose the CMO attendant(s) that provide the service (if desired by the member);
    b. Members are involved with training the CMO attendant(s) (if desired by the member);
    c. Members have the ability to refuse services from a specific CMO attendant(s);
    d. Members are involved in negotiating hours (e.g. time of day) of services;
    e. Members regularly participate in the evaluation of services provided by their CMO attendant(s); and
    f. Members are involved in the supervision of CMO attendant(s) along with the CMO attendant supervisor (if desired by the member, and to the extent of his/her abilities).

4. The member shall have the opportunity to directly be the employer of attendants for supportive home care services as specified in HFS 73.06 and 73.08 Wis Admin. Code.

5. The CMO shall implement and adhere to rules and regulations prescribed by the United States Department of Labor and in accordance with 41 Code of Federal Regulations, Chapter 60.

6. The CMO shall comply with regulations of the United States Department of Labor recited in 20 Code of Federal Regulations, Part 741 and the Federal Rehabilitation Act of 1973. The CMO shall ensure compliance by any and all subcontractors engaged by the CMO under this contract with said regulations.

7. The CMO shall comply with rules and regulations in 1997 Wisconsin Act 27 related to criminal background and other checks.

8. The following requirements pertain to paid providers and CMO staff who come into direct contact with a member but who are not provider types included in the 1997 Wisconsin Act 27, which relates to criminal background checks:

    a. The CMO shall establish and implement a policy to appropriately respond when there is a criminal conviction related for a person who is to be paid to provide services to a member which results in direct contact with a member;

    b. The CMO shall perform, or require providers to perform, criminal background checks on people paid to provide services to a member which results in direct contact with that member;

    c. For CMO provider organizations that have staff providing services that result in direct contact with CMO members, the CMO shall ensure criminal background checks are provided and the organization adheres to the CMO's policy on criminal background checks;

    d. The CMO maintains the ability to not pay any provider if the CMO deems it is unsafe based on the findings of past criminal convictions stated in the criminal background check; and

    e. The criminal background check shall be made available to the member or entity who is the employer.

E. Provider Certification

1. The CMO shall use only providers that:

a. Meet the provider standards in Wisconsin's Home and Community Based Waivers; or

b. Are certified by the Medicaid program for those services in the LTC benefit package that would have been provided under Medicaid fee-for-service; or

c. Meet the CMO's provider standards, which are approved by the State.

2. The following information shall be furnished by the CMO upon the request of a member:

a. The licensure, certification and accreditation status of the managed care organizations and providers in the CMO's provider network; and

b. The education, board certification and recertification of health professions which are certified by Medicaid (e.g. physical therapy).

F. Cultural Competency

1. *Cultural Values.* The CMO shall incorporate in its policies, administration, provider contract, and service practice the values of honoring members' beliefs, being sensitive to cultural diversity, and fostering in staff/providers attitudes and interpersonal communication styles which respect members' cultural backgrounds. The CMO shall have specific policy statements on these topics and communicate them to subcontractors.

2. *Cultural Competency*. The CMO shall encourage and foster cultural competency among CMO staff and providers.

3. *Cultural Preference*. The CMO shall permit members to choose providers from among the CMO's network based on cultural preference.

4. *Complaints and Grievances.* The CMO shall accept complaints and grievances from members related to a lack of access to culturally appropriate care. Culturally appropriate care is care delivered with sensitivity, understanding, and respect for the member's culture.

G. Reproduction and Distribution of Materials

The CMO shall, at the CMO expense, reproduce and distribute information or documents sent to the CMO from the Department that contain information providers must have in order to fully implement this contract. These materials shall be distributed within a reasonable time frame stipulated by the Department.

VI. CMO Functions: Quality Assurance/Quality Improvement

A. QA/QI Plan, Program, and Coordination

1. *QA/QI Plan.* The CMO's governing board or its designee shall approve a written QA/QI work plan that outlines the scope of activity and the goals, objectives, and timelines for the QA/QI program. The QA/QI plan shall provide for systematic data collection of performance and member results for identified goals and outcomes. This QA/QI plan must be submitted to the Department and approved before the effective date of the contract (i.e. the first Health and Community Supports contract between the CMO and the Department). The CMO's governing board or its designee shall set new goals and objectives annually based on findings from quality assurance and improvement activities.

2. *QA/QI Program.* The CMO shall implement a QA program to assure that the quality of care and services it provides either through CMO staff or sub-contracted providers is maintained at acceptable levels. The scope of activities to assure quality must include: potential problem identification through screening; verifying quality-related problems and causes; evaluation of problems to determine severity and whether or not further study is warranted by audit or other means; designing activities to address deficiencies; recommending corrective action plans; assuring the implementation of corrective action plans; and conducting follow-up activities to determine whether or not care meets acceptable standards.

   The CMO shall implement an effective QI program that aims at, through ongoing measurements and CMO interventions, demonstrable and sustained improvement in the selected quality indicator(s) related to member health, functioning and satisfaction. Demonstrable improvement for a particular indicator is defined either as reaching a specific target or as improving performance by a fixed percentage defined in advance by the CMO, or by the Department. The CMO shall evaluate the overall effectiveness of its QA/QI program annually to determine whether the program has demonstrated improvement, where needed, in the quality of service provided to its members.

3. *Department Review and Audit.* The CMO's organizational structure, standards, policies and practices shall allow for individualization to achieve member-defined outcomes. Whenever possible, the CMO shall demonstrate a direct connection between organizational actions and member defined outcomes. The Department will determine the effectiveness of the CMO by evaluating its progress towards achieving personal outcomes for its members.

   The CMO shall have documentation of all aspects of the QA/QI program available for Department review upon request. The Department may perform off-site and on-site QA/QI audits to ensure that the CMO is in compliance with the requirements of this contract. The review and audit may include: on-site visits; staff and member interviews; record reviews; review of QA/QI procedures, reports, committee activities, corrective actions and follow up plans; peer review process; review of the

results of the member satisfaction surveys; and review of CMO staff and provider qualifications.

4. *QA/QI Performance.* The CMO shall achieve required minimum levels of performance on specific measures that may be established by the Department. The CMO shall report such performance to the Department. The CMO shall meet any goals for performance improvement on specific measures that may be established by the Department. See Addendum II, *CMO Quality Indicators* (page 94) for more information.

5. *QA/QI Administrative Structure.* The CMO's QA/QI program shall be administered through clear and appropriate administrative arrangements, such that:

    a. The governing board oversees and is accountable for the QA/QI program.

    b. A designated senior manager, who has direct authority to commit CMO resources to the QA/QI effort, is responsible for QA/QI implementation.

    c. The staffing level and available resources shall be sufficient to provide reasonable assurance that compliance with QA/QI standards are achieved within the maximum permissible time frame (a period to be established by the Department.)

    d. A QA/QI committee or other coordinating structure (that includes both administrative personnel and providers) shall exist to clearly identify individuals or organizational components responsible for each aspect of the QA/QI program and ensure that effective organizational structures are in place to facilitate communication and coordination.

    e. The QA/QI program shall include active participation by:

        - Members or other individuals who meet the functional eligibility for the CMO's target population(s);
        - CMO staff and providers, including attendants and informal caregivers who are able to contribute to the QA/QI effort; and
        - Long term care and health care providers with professional expertise appropriate to the services offered by the CMO.

    f. There shall be a collaboration among all aspects of the QA/QI activity and other functional areas of the CMO impacting the quality of service delivery and clinical care (e.g., utilization management, risk management, complaints and grievances, etc.).

6. *QA/QI Program Records.* The activities of the QA/QI program shall be documented. These documents shall be available to the Department upon request.

7. *Delegation*. The CMO shall oversee and be wholly accountable for any functions or responsibilities that are described in these QA/QI standards and are delegated to any subcontractor. Specific responsibilities of the CMO are:

    a. Before any delegation, the CMO shall evaluate the prospective subcontractor's ability to perform the activities to be delegated;

    b. There shall be a written agreement that specifies the delegated activities and reporting responsibilities of the subcontractor and provides for revocation of the delegation or imposition of other sanctions if the subcontractor's performance is inadequate;

    c. The CMO shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review at least once a year;

    d. If the CMO identifies deficiencies or areas for improvement, the CMO and the subcontractor shall take corrective action.

8. *Performance Improvement Project.* The CMO shall complete one Performance Improvement Project by the end of this contract. The requirements for the Performance Improvement Projects are addressed in Addendum VIII, *Performance Improvement Projects* (page 111).

B. Member Input

1. *Communication Processes.* The language and practices of the CMO shall recognize each member as an individual and emphasize each member's capabilities. CMO staff shall demonstrate dignity and respect their interactions with members.

2. *Ongoing Member Participation.* The CMO shall create a means for members to continually participate in CMO quality improvement and give input and feedback on the quality of the CMO services. Some methods for this ongoing member participation, feedback and input include: focus groups; consumer advisory councils; member participation on the governing board; the QA/QI committee or other committees; surveys of members who disenrolled; or task forces related to evaluating services. The CMO shall reach out to diverse member populations, such as frail, homebound members, to provide opportunities for participation, input, or feedback. Documentation of outreach efforts to solicit feedback from members shall be available to the Department upon request.

3. *Annual Member Feedback on CMO Performance.* In addition to the ongoing member participation described above, at least annually the CMO must seek formal member input, through member surveys, face-to-face interviews or other means, on:

    a. The effectiveness of its communications with members;
    b. Access and availability for services in and outside of the LTC benefit package;
    c. Choice and continuity;

d. Changes in functional and health status of members; and
e. Other information of interest to consumers.

The results of the annual member feedback on CMO performance shall be made available to the Department and members upon request. The purpose of this activity is to identify successes, potential problems and barriers to care and to provide potential members with information they need to choose a CMO.

The CMO shall have systems in place for acting on member feedback in a timely way, and shall report to the Department the results and any quality management projects planned in response to the results. The annual member feedback activity can be used to obtain information for a Performance Improvement Project, as discussed in Addendum VIII, *Performance Improvement Projects* (page 111).

C. Provider Selection and Retention

The CMO shall implement a selection and retention process that meets the requirements of this section.

1. *Individual practitioners*[2]. For each individual practitioner who provides services to CMO members, the process must include the following:

   a. Initial selection is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

   b. Reassessment of individual practitioners' shall be accomplished:

      - Every two years; and
      - Through a process that updates information obtained during the initial selection process and considers performance indicators, including those obtained through the following:
        - The QA/QI program;
        - The utilization management system;
        - The complaint and grievance system;
        - Member satisfaction surveys; and
        - Other CMO activities.

2. *Other providers.* For providers who do not meet the definition of individual practitioner (this includes individual providers such as personal care workers and home health aides, and agency providers such as nursing facilities and home health agencies), the initial selection process and reassessment at specified intervals shall be accomplished to ensure that, at a minimum, the provider is licensed (if the

[2] For the purposes of this section, "practitioner" includes psychologists, physical or occupational therapists or therapist assistants, speech-language pathologists, registered or licensed practical nurses, certified social workers, registered respiratory therapists, other health, mental health, or AODA professionals licensed by the state.

Department requires licensing to operate in the State) and is in compliance with any other Federal or State requirements.

3. The CMO's use of formal selection and retention criteria shall not discriminate against particular practitioners or other providers, such as those who serve high risk populations, or specialize in conditions that require costly treatment.

D. Availability of Member Records

Member records must be readily available for CMO-wide QA/QI and Utilization Management activities. (See following section, *Authorization of Services and Utilization Management.*)

E. Authorization of Services and Utilization Management

1. *Policies*. The CMO shall have documented policies and procedures for determining approval or denial of services. These policies require review and approval by the Department before the effective date of this contract. These policies shall be stated in the Member Handbook.

   a. Policies must take into account anticipated long term social and quality of life issues. Such consideration includes implications for independent living, support for the least restrictive residential setting for the member, and skill acquisition for the member to perform activities of daily living.

   b. The CMO shall specify information required for advance authorization decisions, have mechanisms to ensure consistent application of review criteria for advance authorization decisions, and consult with the requesting provider when appropriate.

   c. Policies shall specify time frames for responding to requests for initial and continued determinations as expeditiously as the member's situation requires.

   d. Qualified professionals must be involved in any decision-making that requires professional or discipline-specific judgment.

   e. All requests for advance authorization of services by a member or a provider shall be recorded, along with the disposition. Aggregate data are compiled for use in quality assessment and monitoring and are available upon request by the Department.

   f. The CMO shall provide written notification to the member when a decision is made to deny or limit a member's request for a services; or to terminate, reduce, or suspend a current service; or to deny payment for a service. (See Article IV.D, *Notice of CMO Intention*, page 33, for specifics).

      The CMO shall provide written notification to the provider when a decision is made to not act on a claim for services in the timeframe previously agreed upon

with the provider. (See Article V.C(5), *Appeals to the CMO and Department for Payment/Denial of Providers Claims,* page 48, for related information).

g. The CMO shall communicate to providers, upon request, criteria used for review and approval of specific services.

h. The CMO does not prohibit providers from advocating on behalf of members within the utilization management process.

i. The CMO shall provide that compensation to individuals or entities that conduct utilization management or prior authorization activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue services necessary to achieve outcomes to any enrollee.

F. External Quality Review

1. *Assistance to Department and External Quality Review.* The CMO shall assist the Department and the external quality review organization under contract with the Department in identification of provider and member information required to carry out on-site or off-site member record reviews. The provider of service may elect to have member records reviewed on-site or off-site.

2. *CMO's Tasks.* When the external quality review organization under contract with the Department identifies quality deficiencies which need to be followed up on, the CMO shall be responsible for the following tasks:

   a. Assign a staff person(s) to conduct follow-up with the CMO manager or the CMO provider(s) concerning each quality deficiency identified by the Department's external quality review organization, including informing the provider(s) of the finding and monitoring the provider's resolution of the finding. Follow up with the appropriate CMO manager is conducted when the service is directly provided by the CMO. Follow up with the CMO provider is conducted when the service is subcontracted;

   b. Inform those participating in the CMO's QA/QI program of the follow up activities and final findings. Involve those participating in the QA/QI program in the development, monitoring, and resolution of the corrective action plan; and

   c. Submit a corrective action plan or an opinion in writing to the Department within 60 days that describes the measures that the CMO and the provider intend to take to resolve the finding. The CMO's final resolution of all potential Quality Improvement cases must be completed within six months of the notification to the CMO. A case is not considered resolved by the Department until the Department approves the response submitted by the CMO and provider.

3. *Training.* The CMO shall facilitate training provided by the Department to the CMO's providers.

4. *Availability of Results.* The results of the review shall be made available to the Department, CMO providers, and members in a manner that does not disclose the identity of any individual member.

VII. CMO Functions: Administration

A. Financial Management

1. *Elements of Financial Management.* The CMO is responsible for sound financial management practices which maximize the value and quality of services provided for the funds expended. The CMO's financial management systems shall include the following at a minimum:

    a. Systems to ensure that information used for financial management and reporting purposes is timely, accurate and complete;

    b. An accounting system adequate to manage the business needs of a managed care organization;

    c. Policies and procedures, including innovative practices, to ensure effective cost control;

    d. Policies and procedures regarding the accumulation and appropriate utilization of the solvency protections as specified in Addendum III, *Solvency Protection Requirements* (page 99); and

    e. Practices to ensure the cost-effective use of available resources, including per member per month payments (Article IX.A, *Per Member Per Month Payment Rates*, page 70), Medicare and other third party liability payment sources (Article IX.F, *Third Party Liability (TPL)*, page 71), 1915(c) waiver post eligibility treatment of income (Article III.A (10), *Billing Members*, page 27), and private pay case management (Article III.A (11), *Private Pay Care Management*, page 28).

2. *Business Plan.* The CMO shall develop a three-year business plan which receives approval from the Department prior to the effective date of this contract. The business plan shall contain the following elements at a minimum:

    a. Monthly enrollment plan of census projections, showing the CMO's steps toward serving the target population(s) in a timeframe agreed upon with the Department. The CMO shall submit an updated enrollment plan prior to the end of this contract period, and receive Department approval of the plan before the effective date for the subsequent contract period;

b. Monthly budget projections, including expenses for additional care management teams and other staff necessary to serve the added enrollment; and

c. Monthly revenue projections.

B. Member Records

The CMO shall have a system for maintaining member records and for monitoring compliance with their policies and procedures.

1. The CMO shall implement specific procedures to assure the confidentiality of health and medical records and of other personal information about members, including:

   a. Members have the right to approve or refuse the release of personally identifiable information, except when such release is authorized by law;

   b. Original medical records shall be released only in accordance with federal or state law, or court orders or subpoenas;

   c. Copies of records and information from the CMO shall be released only to authorized individuals; and

   d. Unauthorized individuals shall be prohibited from gaining access to, or altering, member records.

2. Members shall have access to their records in accordance with applicable state or federal law. The CMO shall use best efforts to assist a member, his/her authorized representatives, and others designated by the member to obtain records within ten working days of the request. The CMO shall identify an individual who can assist the member and his/her authorized representatives in obtaining records.

3. The CMO is a contractor of the State and is therefore entitled to obtain records according to Wisconsin Administrative Code, HFS 104.01(3), on Confidentiality of Medical Information. The Department requires Medicaid-certified providers to release relevant records to the CMO to assist in compliance with this section. Where the CMO has not specifically addressed photocopying expenses in their provider subcontracts or other arrangements, the CMO is liable for charges for copying records only to the extent that the Department would reimburse on a fee-for-service basis.

4. Member records shall be accurate, legible and safeguarded against loss, destruction, or unauthorized use.

5. Member records shall be maintained on all members. Member records, and any other information, whether in oral, written or electronic format, shall be updated on a timely basis and maintained in an organized fashion to permit effective member care and service and accessibility for review and audit. Documentation in member records must reflect all aspects of care and be readily available for member encounters, for administrative purposes.

6. The CMO shall maintain, or require the CMO subcontractors to maintain, individual member records in accordance with established professional standards, for each member. The CMO shall make all pertinent and sufficient information relating to the management of each member's medical and long term care readily available to the Department and to appropriate health professionals.

7. The CMO shall have procedures to provide for prompt transfer of records to other non-CMO providers for the management of the member's medical and long term care, and the appropriate exchange of information among the CMO and non-CMO providers receiving referrals.

8. Member records shall be readily available for CMO-wide QA/QI and Utilization Review activities. The member records shall provide adequate medical and long term care service information, and other clinical data needed for QA/QI and Utilization Review purposes, and for investigating member complaints and grievances.

9. The CMO shall have adequate information and record transfer procedures to provide continuity of care when members are treated by more than one provider.

10. A member record shall contain at least the following items:

    a. Face Sheet of demographic information;
    b. LTC Functional Screen;
    c. Community Options Program Functional Screen;
    d. Assessment;
    e. Re-assessment(s);
    f. Individual Service Plan;
    g. Advance directive (if there is one completed);
    h. Guardianship, power of attorney (if there is one completed);
    i. Casenotes by CMO care management team members;
    j. Cost share forms/documentation (if there is any);
    k. Complaints and grievance documentation/forms (if any filed); and
    l. Signed Enrollment Request.

    Minimum member record documentation per chart entry or encounter must conform to the Wisconsin Administrative Code, Chapter HFS 106.02(9)(b), Medical and Financial Record keeping, and to HFS 107.32(1)(d), Case Management Services when applicable to the member encounter.

C. Coordination with Local Long Term Care Council

The Local Long Term Care Council (LLTCC) is responsible for general planning and oversight functions which are specified in s. 46.282 (3) Wis. Stat. The CMO shall cooperate with the LLTCC and assist it to successfully complete its duties. At a minimum, the CMO shall perform the following:

1. The CMO shall provide the LLTCC with information on complaints and grievances, enrollments and disenrollments, agreements and memorandums of understanding with the Resource Center (if applicable), provider networks, and service utilization. This informational need can be met by providing the following documents to the LLTCC, which are already requirements elsewhere in this contract:

    a. Annual Complaint and Grievance Reports (see Article IV.K, *Documentation and Reporting* (page 37);

    b. Quarterly Narrative Reports (see Article X.B (4), *Narrative Reports*, page 74);

    c. List of CMO providers from the member handbook and updated lists (see Article II.B, *Member Handbook*, page 7);

    d. Adequate Service Coverage Plan and plan updates (see Article V.B(7)(b), *Before Effective Date of Contract*, page 40);

    e. Quarterly Financial Reports (see Article X.B(3), *Financial Reports*, page 74); and

    f. Any agreements and memorandums of understanding with Resource Centers and their updates;

2. The CMO shall receive and give consideration to the LLTCC's recommendations on the following:

    a. The CMO provider network in regard to developing a network of providers which is accessible, convenient and desirable;
    b. Whether to offer optional services which are provided through Medicaid fee-for-service (see Article III.A(5), *Services Coordinated Through Medicaid Fee-For-Service*, page 17, for the list of services) and strategies to offer such services if recommended;
    c. Strategies to improving interactions with the Resource Center; and
    d. Strategies to improving the CMO based on a review of the CMO Annual Complaint and Grievance Report.

D. Accessibility of Language

The CMO shall provide materials in formats accessible due to language spoken and various impairments, including but not limited to Braille and large print. Materials shared with potential members and members shall be understandable in language and format based on the following:

1. Material directed at a specific member (e.g. written communication of intention to deny a service): shall be in the language understood by the individual.

2. Material directed at potential members or members in general (e.g. member handbook): shall be provided in languages prevalent in the CMO service area, and in accessible formats (e.g. Braille, large print).

3. All materials: shall be in easily understood language and format. Materials shall take into account individuals with limited reading proficiency.

4. The CMO shall provide instructions to members and potential members in the materials on how to obtain information in the appropriate language or accessible format (e.g. sign language) and how to access such translation/interpreter services.

E. Civil Rights

1. The CMO assures that it has submitted to the Department's Affirmative Action/Civil Rights Compliance Office a current copy of its two-year Civil Rights Compliance Action Plan for Meeting Equal Opportunity Requirements under Title VI and VII of the Civil Rights Act of 1964, Sections 503 and 504 of the Rehabilitation Act of 1973, Title VI and XVI of the Public Health Service Act, the Age Discrimination in Employment Act of 1967, the Age Discrimination Act of 1975, the Omnibus Reconciliation Act of 1981, the Americans with Disabilities Act (ADA) of 1990, and the Wisconsin Fair Employment Act. If a Plan was reviewed and approved during the previous year, a plan update must be submitted for this contract period.

2. No otherwise qualified person shall be excluded from participation in, be denied the benefits of, or otherwise be subject to discrimination in any manner on the basis of race, color, national origin, sexual orientation, religion, sex, disability or age. This policy covers eligibility for and access to service delivery, and treatment in all programs and activities. All employees of the CMO are expected to support goals and programmatic activities relating to nondiscrimination in service delivery.

3. Except where s. 111.337 Wis. Stat. applies, no otherwise qualified person shall be excluded from employment, be denied the benefits of employment or otherwise be subject to discrimination in employment in any manner or term of employment on the basis of age, race, religion, sexual orientation, color, sex, national origin or ancestry, handicap (as defined in Section 504 and the ADA), arrest or conviction record, marital status, political affiliation, or military participation. All employees are expected to support goals and programmatic activities relating to non-discrimination in employment.

4. The CMO shall post the Equal Opportunity Policy, the name of the Equal Opportunity Coordinator and the discrimination complaint process in conspicuous places available to applicants and people who use the CMO's services, and applicants for employment and employees. The complaint process will be according to Department standards and made available in languages and formats understandable to applicants, people who use the CMO's services and employees. The Department will continue to provide appropriate translated program brochures and forms for distribution.

5. The CMO agrees to comply with the Department's guidelines in the Civil Rights Compliance (CRC) Standards and the Resource Manual for Equal Opportunity in

Service Delivery and Employment for a Department of Health and Family Services, its Service Providers and their Subcontractors (October 1997 Edition).

6. Requirements herein stated apply to any subcontracts or contracts. The CMO has primary responsibility to take constructive steps, as per the CRC Standards and Resource Manual, to ensure the compliance of its subcontractors. However, where the Department has a direct contract with another subcontractor, the CMO need not obtain a Subcontractor Civil Rights Compliance Action Plan or monitor that subcontractor.

7. The Department will monitor the Civil Rights Compliance of the CMO. The Department will conduct reviews to ensure that the CMO is ensuring compliance by its subcontractors according to guidelines in the CRC Standards and Resource Manual. The CMO agrees to comply with Civil Rights monitoring reviews, including the examination of records and relevant files maintained by the CMO, as well as interviews with staff, clients, applicants for services, subcontractors, and referral agencies. The reviews will be conducted according to Department procedures. The Department will also conduct reviews to address immediate concerns of complainants.

8. The CMO agrees to cooperate with the Department in developing, implementing and monitoring corrective action plans that result from complaint investigations or monitoring efforts.

9. The CMO agrees that it will:

    a. Hire staff with special translation or sign language skills and/or provide staff with special translation or sign language skills training, or find qualified persons who are available within a reasonable period of time and who can communicate with limited- or non-English speaking or speech- or hearing-impaired clients at no cost to the client;

    b. Provide aids, assistive devices and other reasonable accommodations to the client during the application process, in the receipt of services, and in the processing of complaint or appeals;

    c. Train staff in human relations techniques, sensitivity to persons with disabilities and sensitivity to cultural characteristics;

    d. Make programs and facilities accessible, as appropriate, through outstations, authorized representatives, adjusted work hours, ramps, doorways, elevators, or ground floor rooms, and Braille, large print or taped information for the visually or cognitively impaired; and

    e. Post and/or make available informational materials in languages and formats appropriate to the needs of the target populations.

F. Ineligible Organizations

Upon obtaining information or receiving information from the Department or from another verifiable source, the CMO shall exclude from participation in the CMO all organizations which could be included in any of the following categories (references to the Act in this section refer to the Social Security Act):

1. *Ineligibility*. Entities which could be excluded under Section 1128(b)(8) of the Social Security Act are entities in which a person who is an officer, director, agent or managing employee of the entity, or a person who has a direct or indirect ownership or control interest of 5% or more in the entity, or a person with beneficial ownership or control interest of 5% or more in the entity has:

    a. Been convicted of the following crimes:

    - Program related crimes, i.e., any criminal offense related to the delivery of an item or service under Medicare or Medicaid (see Section 1128(a)(1) of the Act);

    - Patient abuse, i.e., criminal offense relating to abuse or neglect of patients in connection with the delivery of health care (see Section 1128(a)(2) of the Act);

    - Fraud, i.e., a State or Federal crime involving fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of health care or involving an act or omission in a program operated by or financed in whole or part by Federal, State or local government (see Section 1128(b)(1) of the Act);

    - Obstruction of an investigation, i.e., conviction under State or Federal law of interference or obstruction of any investigation into any criminal offense described directly above (see Section 1128(b)(2) of the Act); or

    - Offenses relating to controlled substances, i.e., conviction of a State or Federal crime relating to the manufacture, distribution, prescription or dispensing of a controlled substance (see Section 1128(b)(3) of the Act).

    b. Been Excluded from Participation in Medicare or a State Health Care Program. A State health care program means a Medicaid program or any State program receiving funds under title V or title XX of the Act. (See Section 1128(b)(8)(iii) of the Act.)

    c. Been Assessed a Civil Monetary Penalty under Section 1128A of the Act. Civil monetary penalties can be imposed on individual providers, as well as on provider organizations, agencies, or other entities by the DHHS Office of Inspector General. Section 1128A authorizes their use in case of false or fraudulent submittal of claims for payment, and certain other violations of payment practice standards. (See Section 1128(b)(8)(B)(ii) of the Act.)

2. *Contractual Relations.* Entities which have a direct or indirect substantial contractual relationship with an individual or entity listed above in subsection (a). A substantial contractual relationship is defined as any contractual relationship which provides for one or more of the following services:

    a. The administration, management, or provision of medical or long term care services;
    b. The establishment of policies pertaining to the administration, management, or provision of medical or long term care services; or
    c. The provision of operational support for the administration, management, or provision of medical or long term care services.

3. Entities which employ, contract with, or contract through any individual or entity that is excluded from participation in Medicaid under Section 1128 or 1128A of the Act, for the provision (directly or indirectly) of Health Care, Utilization Review, Medical Social Work or Administrative Services. For the services listed, the CMO shall exclude from contracting with any entity which employs, contracts with, or contracts through an entity which has been excluded from participation in Medicaid by the Secretary under the authority of Section 1128 or 1128A of the Act.

    The CMO attests by signing this contract that it excludes from participation in the CMO all organizations which could be included in any of the above categories.

G. Compliance with Applicable Law

The CMO shall observe and comply with all Federal and State law in effect when this contract is signed or which may come into effect during the term of this contract, which in any manner affects the CMO's performance under this contract, except as specified in Article III.A, *Provision of Services in the LTC Benefit Package* (page 14).

H. Clinical Laboratory Improvement Amendments

When coordinating laboratory services, the CMO shall use only laboratories that have a valid Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate along with a CLIA identification number and that comply with the CLIA regulations as specified by 42 CFR Part 493, "Laboratory Requirements." Those laboratories with certificates will provide only the types of tests permitted under the terms of 42 CFR Part 493.

I. Annual Audit

1. *Requirement to Have an Audit.* The CMO shall submit an annual financial audit, including "Letters to Management", by June 1 of the year following this contract.

2. *Audit Requirements.* The audit shall be a financial audit in accordance with the Government Auditing Standards issued by the United States General Accounting Office. Audit must include testing of compliance with program and financial requirements identified in audit guidelines prepared by the Department. If the CMO is

governed by a single county, the audit of the CMO may be a part of the county's annual audit.

The per member per month payments made by the Department to the CMO are not defined as Federal financial assistance for purposes of determining whether the audit needs to be in accordance with OMB Circular A-133.

3. *Submitting the Reporting Package.* Two copies of the audit report shall be sent to the Department at the following address:

   Office of Program Review and Audit
   Department of Health and Family Services
   P.O. Box 7850
   Madison, WI 53707-7850

   Telephone: (608) 266-2924

4. *Access to Auditor's Workpapers.* When contracting with an audit firm, the CMO shall authorize its auditor to provide access to work papers, reports, and other materials generated during the audit to the appropriate representatives of the Department. Such access shall include the right to obtain photocopies of the workpapers and computer disks, or other electronic media, upon which records / working papers are stored.

5. *Access to Agency Premises and Records.* The CMO shall allow duly authorized agents or representatives of the Department or the Federal government, during normal business hours, access to the CMO's premises (or to any subcontractor's premises) to inspect, audit, monitor or otherwise evaluate the performance of the CMO's or subcontractor's contractual activities and shall within a reasonable time, but not more than 10 business days, produce all records requested as part of such review or audit. In the event right of access is requested under this provision, the CMO or subcontractor shall, upon request, provide and make available staff to assist in the audit, evaluation, or inspection effort, and provide adequate space on the premises to reasonably accommodate the Department or Federal personnel conducting the audit, evaluation, or inspection effort. All inspections, evaluations, or audits shall be conducted in a manner as will not unduly interfere with the performance of CMO's or subcontractor's activities.

6. *Failure to Comply with the Requirements of this Section.* In the event that the CMO fails to have an appropriate audit performed or fails to provide a complete audit report to the Department within the specified timeframes, in addition to applying one or more of the remedies available under this contract, the Department may:

   a. Conduct an audit or arrange for an independent audit of the CMO and charge the cost of completing the audit to the CMO; and/or

b. Charge the CMO for all loss of Federal or State aid or for penalties assessed to the Department because the CMO did not submit a complete audit report within the required timeframe.

J. Access to Premises and Information

1. *Access to Premises.* The CMO shall allow duly authorized agents or representatives of the State or Federal government, during normal business hours, access to the CMO's premises or the CMO subcontractors' premises to inspect, audit, monitor or otherwise evaluate the performance of the CMO's or subcontractors' contractual activities and shall forthwith produce all records requested as part of such review or audit. In the event right of access is requested under this section, the CMO or subcontractor shall, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the State or Federal personnel conducting the audit or inspection effort. The Department may perform off-site audits or inspections to ensure that the CMO is in compliance with contract requirements.

   All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of the CMO's or subcontractor's activities. The CMO shall be given 15 working days to respond to any findings of an audit before the Department shall finalize its findings. All information so obtained will be accorded confidential treatment as provided under applicable law.

2. *Access to and Audit of Contract Records.* Throughout the duration of this contract, and for a period of five years after termination of this contract, the CMO shall provide duly authorized representatives of the State or Federal government access to all records and material relating to the contract's provision of and reimbursement for activities contemplated under this contract. Such access shall include the right to inspect, audit and reproduce all such records and material and to verify reports furnished in compliance with the provisions of this contract. All information so obtained will be accorded confidential treatment as provided under applicable law.

3. *State Contracted Independent Advocacy Entity*. The CMO shall comply with the Department's direction in regard to the work of the State contracted independent advocacy entity for Family Care.

VIII. Functions and Duties of the Department

In consideration of the functions and duties of the CMO contained in this contract:

A. State Long Term Care Council

The Department shall have a State Long Term Care Council which consists of 15 members. The council shall performs the following duties at a minimum:

1. Assist the Department in developing broad policy issues related to long term care services.

2. Assist the Department in developing, implementing, coordinating and guiding long term care services and systems, including making nonbinding recommendations to Department regarding: a) Department standard contract provisions for Resource Centers and CMOs, b) the Family Care benefit, including the per member per month rate structure, c) the community options program, d) the community integration programs, and e) provision of services in the Medicaid fee-for-service system;

3. Monitor and review: a) pattern of complaints and grievances related to long term care in order to identify statewide issues, b) number of people on waiting lists, c) pattern of service utilization by CMOs, and d) pattern of CMO enrollment and disenrollments throughout the State;

4. Annually report to the legislature and the governor on the status, achievements, problems of Resource Centers and CMOs including: a) number of people served, b) costs of long term care provided under Family Care, c) number and services areas of Resource Centers and CMOs, d) waiting lists information, and e) results of reviews of quality of services provided by Resource Centers and CMOs;

5. Ensure continual training is coordinated by the Department and offered to CMOs;

6. Ensure forums are created for the sharing of best practice among CMOs; and

7. Review quarterly reports on the CMOs' activities and make recommendations for continually improving operations and services to the membership.

B. Reports from the CMOs

The Department shall have systems in place to ensure that reports and data required to be submitted by the CMO shall be reviewed and analyzed by the Department in a timely manner. The Department shall respond accordingly to any indications that the CMO is not making progress toward meeting all performance expectations (e.g., providing timely and accurate feedback to the CMO, and offering technical assistance to help the CMO correct any operational problems).

C. Enrollment

The Department shall notify the CMO two times per month of all members enrolled in the CMO under this contract. Notification shall be effected through CMO Enrollment Reports. All members listed as an ADD or CONTINUE on either the Initial or Final CMO Enrollment Reports are members of the CMO during the enrollment month. The reports shall be generated in the sequence specified under the CMO Enrollment Reports. These reports shall be in both tape and hard copy formats and shall include Medical Status Codes.

D. Family Care ID Cards

The Department will issue new members a Family Care ID card which will provide indication of the member's enrollment in the specific CMO. This card will be issued after enrollment. The card will be a plastic magnetic stripe identification card.

E. Disenrollment

The Department will promptly notify the CMO of all members no longer eligible to receive services through the CMO under this contract. Notification shall be effected through the CMO Enrollment Reports which the Department will transmit to the CMO for each month of coverage throughout the term of the contract. The reports shall be generated in the sequence under the CMO Enrollment Reports. Any member who was enrolled in the CMO in the previous enrollment month, but does not appear as an ADD or CONTINUE on either the Initial or Final CMO Enrollment Report for the current enrollment month, is disenrolled from the CMO effective the last day of the previous enrollment month. See Article III.A(8), *Payments for Services* (page 27) regarding conditions for members who continue to have a valid Family Care ID card.

F. Enrollment Reports

For each month of coverage throughout the term of this contract, the Department shall transmit CMO Enrollment Reports to the CMO. These reports will provide the CMO with ongoing information about its members and disenrollees and will be used as the basis for the monthly per member per month claims described in Article IX.E, *Payment Schedule* (page 70). Enrollment Reports will be generated in the following sequence:

1. *Initial Report*. The Initial CMO Enrollment Report will list all of the CMO's members and disenrollees for the enrollment month who are known on the date of report generation. The Initial CMO Enrollment Report will be received by the CMO on or before the fifth day of each month covered by the contract. Each member listed as an ADD or CONTINUE on this report will be listed on the payment report. Members who appear as PEND/CLOSE on the Initial Report and are reinstated into the CMO during the month will appear as an ADD or CONTINUE on the Final Report.

2. *Final Report*. The final CMO Enrollment Report will list all of the CMO's members for the enrollment month, who were not included in the Initial CMO Enrollment Report. The Final CMO Enrollment Report will be received by the CMO on or before the fifteenth day of each month subsequent to the coverage month. Each member listed as an ADD or CONTINUE on this report will be listed on the payment report. Members in PEND/CLOSE status will not be included on the final report.

G. Utilization Review and Control

The Department will waive, to the extent allowed by law, any present Department requirements for prior authorization, second opinions, co-payment, or other Medicaid restrictions for the provision of services in the LTC benefit package provided by the CMO to members.

H. Right to Review

The Department will submit to the CMO for prior approval materials that describe the CMO and that will be distributed by the Department or County to potential members and members.

I. Review of Study or Audit Results

The Department shall submit to the CMO for a 15 working day review/comment period, any studies or audits that are going to be released to the public that are about the CMO and Medicaid.

IX. Payment to CMO

A. Per Member Per Month Payment Rates

In full consideration of services in the LTC benefit package rendered by the CMO, the Department agrees to pay the CMO monthly payments based on the per member per month payment rate specified in Addendum VI, *Actuarial Basis* (page 108). The per member per month payment rate shall be prospectively designed to be less than the cost of providing the same services covered under this contract to a comparable Medicaid population on a fee-for-service basis. The per member per month payment rate shall not include any amount for recoupment of losses incurred by the CMO under previous contracts.

B. Actuarial Basis

The per member per month payment rate is calculated on an actuarial basis (specified in Addendum VI, *Actuarial Basis* (page 108) recognizing the payment limits set forth in 42 CFR 447.361.

C. Renegotiation

The monthly per member per month payment rates set forth in this Article shall not be subject to renegotiation during the contract term or retroactively after the contract term, unless such renegotiation is required by changes in Federal or State law.

D. Reinsurance

The CMO may obtain a risk-sharing arrangement from an insurer other than the Department for coverage of members under this contract, provided that the CMO remains substantially at risk for providing services under this contract.

E. Payment Schedule

Payment to the CMO shall be based on CMO Enrollment Reports which the Department will transmit to the CMO. The CMO shall accept payments under this contract as payment in full and shall not bill, charge, collect or receive any other form of payment from the Department and the member except as permitted by Medicaid regulations as specified in Article III.A(10), *Billing Members* (page 27).

F. Third Party Liability (TPL)

The CMO shall actively pursue, collect and retain any monies from third party payers for services in the LTC benefit package to members except where the amount of reimbursement the CMO can reasonably expect to receive is less than the estimated cost of recovery. Records shall be maintained of all third party collections and reports shall be made quarterly on the form designated by the State in Addendum V, *TPL Report Format* (page 106). The CMO shall be able to demonstrate that appropriate collection efforts were made and followed up on. The CMO shall seek from members information on TPL.

TPL may include, but is not limited to, all other State or Federal medical care programs which are primary to Medicaid, group or individual health insurance and casualty collections.

Casualty collections means any recoverable amounts arising out of settlement of torts or Worker's Compensation. State subrogation rights have been extended to the CMO under s. 49 Wis. Stats., including s. 49.89.

Where the CMO has entered a risk-sharing arrangement with the Department, the collection and distribution of third party liabilities shall follow the procedures described in Addendum III, *Solvency Protection Requirements*, (page 99).

Collections from third party payers are the responsibility of the CMO or its subcontractors. The CMO and subcontractors shall not pursue collection from the member but directly from the third party payer.

G. Recoupments and Retrospective Payment Adjustments

The Department will not normally recoup per member per month payments made to the CMO when the CMO actually provided service or the person is subsequently determined ineligible. However, the Department may recoup per member per month payments made to the CMO in the following situations:

1. *Change of Eligibility Status*. The Department will recoup per member per month payments when a member's status has changed before the first day of a month for which a per member per month payment has been made because:
   c. The member voluntarily disenrolls;
   d. The member fails to meet functional or financial eligibility and the member has exhausted his/her grievances processes including a fair hearing which the member has requested;
   e. The member initiates a move out of the CMO service area;
   f. The member fails to pay, or to make satisfactory arrangements to pay, any cost share amount due the CMO after a 30 day grace period;
   g. The member dies; or
   h. The member enters a public institution (as defined in 42 CFR 435.1008).

2. *Disputed Membership*. When membership is disputed, the Department shall be the final arbitrator of membership and reserves the right to recoup an inappropriate per member per month payment.

3. *Contract Termination*. If this contract is terminated, recoupments will be accomplished through a payment by the CMO within 30 days of contract termination.

4. *Adjustments – Quarterly Rate Review.* Within 30 days of the end of each quarter of this contract, the Department will formally review, at a minimum, 1998 historical Medicaid costs for the entire cohort of actual members of the CMO, and compare the result to the prospective rate. The methodology for calculating a retrospective rate will be the same as that used to calculate the prospective rate, but using actual member historical cost data prior to enrollment in the CMO. The Department will adjust the retrospective rate to account for cost differences among people new to Medicaid and/or the Home and Community Based Waiver programs. If the CMO is in a situation where the number of enrolled high cost members would significantly increase the CMO per member per month payment, (i.e., by 10% or more), a quarterly lump sum payment will be paid to the CMO. During this contract period, the Department will make no recoupments. If, at the end of the contract period, the CMO is in a situation where the retrospective CMO per member per month payment rate is less than the prospective per member per month payment rate, the Department will recoup the difference between the rates for every eligible month. If, after two quarters, the quarterly adjustment results in a significant change (+/- 20%) in the CMO per member per month payment, the prospective rate will be changed accordingly.

X. Reports and Data

A. Management Information System

1. The CMO shall meet all of the reporting requirements as specified in this contract in a timely way, assure the accuracy and completeness of the data, and submit the reports/data in a timely manner. Data submitted to the Department shall be supported by records available for inspection or audit by the Department. The CMO shall designate a contact person responsible for the computer/data reporting who is available to answer questions from the Department and resolve any issues regarding reporting requirements. The CMO's Management Information System (MIS) shall be sufficient to support quality assurance/quality improvement requirements described in Article VI, *CMO Functions: Quality Assurance/Quality Improvement* (page 52).

2. The CMO shall have a claims processing system which meets the specifications of Article V.C(3), *Thirty Day Payment Requirement*, and (4) *Claims Retrieval System* (page 47).

3. During the year 2000 and 2001, the CMO shall report member-specific data on the HSRS Long Term Support Module as directed by the Department. CMO staff will participate in the planning and development of data reporting requirements for future contracts. This participation will include attending workgroup meetings, addressing

necessary changes to local databases, and cooperating with the Department on data submission protocol and testing.

Prior to the effective date of the contract for the year 2001, the CMO shall meet certification standards to demonstrate it has the MIS capacity to:

a. Analyze, integrate and report data;

b. Capture and maintain a member level record of all services in the LTC benefit package, and provided to members by the CMO and its providers, in a computerized data base adequate to meet the reporting requirements of the contract;

c. Monitor enrollment and disenrollment, in order to determine which members are enrolled or have disenrolled from the CMO on any specific day;

d. Collect and accurately produce data, reports, and member histories including, but not limited to, member and provider characteristics, encounter data, utilization, disrenrollments, solvency, complaints and grievances which satisfies the reporting requirements identified under (B) *Reports: Regular Interval*, and (C) *Reports: As Needed* of this Article; and

e. Ensure that data received from providers, and reported to the Department, is timely, accurate and complete, by:

- Verifying the accuracy and timeliness of reported data;
- Screening the data for completeness, logic, and consistency;
- Collecting information on services in standardized formats, such as the HCFA 1500 or UB92 format, or other uniform format, to the extent possible;
- Recording and tracking all services with a unique member identification number (the Medicaid ID number shall be recorded for all members who are Medicaid recipients).

4. Beginning January 1, 2002, the CMO shall report member-specific data to the Department in an encounter-data format specified by the Department. Prior to the effective date of the contract for 2002, the CMO shall meet certification standards that demonstrate it has the MIS capacity to meet the Department reporting requirements in the formats and timelines prescribed by the Department.

B. Reports: Regular Interval

The CMO agrees to furnish information from its records to the Department, and to the Department's authorized agents, which the Department may require to administer this contract. See Addendum IV, *Reporting* (page 103), for a compilation of these and other reports/documents and due which are specified in this contract. The reports with a regular interval include, but not limited to the following:

1. *Third Party Liability (TPL) Report.* Summaries of amounts recovered from third parties for services rendered to members under this contract in the format specified in Addendum V, *TPL Report Format* (page 106). TPL Reports are due 30 days after the end of each quarter.

2. *Client Specific Data Report*. The Client Specific Data Report is a monthly report. The report is due 30 days after the reporting period. The Client Specific Data Report contains the following components:

    a. Reporting on the Long Term Support Module of HSRS which has been modified for CMOs reporting. It will be used to report member specific enrollment and disenrollment, utilization of services and expenditure in the LTC benefit package, and member characteristic/demographics. The HSRS reporting shall be reported on-line or through a batch methodology approved by the Department.

    b. Other client specific data required by the Department. The reporting shall be reported by a methodology approved by the Department.

3. *Financial Report.* The quarterly Financial Report is due 30 days after the reporting period. The Quarterly Financial Report contains the following components:

    a. Budgeted versus Actual Financial Report, for current and year-to-date periods;
    b. Incurred but not reported costs;
    c. Cumulative Costs; and
    d. Fiscal data based on cost center accounting structure in a format specified by the Department.

4. *Narrative Report.* The quarterly Narrative Report is due 30 days after the reporting period. The Quarterly Narrative Report contains the following components:

    a. Census and outreach activities
    b. Member participation
    c. Provider network
    d. Staff recruitment and selection
    e. Training and staff development
    f. QA/QI activities and other special studies
    g. Grievances processed (e.g. nature of the grievance, the outcome)
    h. Financial management systems development
    i. Information technology systems development
    j. Resource Center and CMO interactions
    k. Collaborative activities
    l. Barriers and Solutions
    m. Plan for next quarter

5. *Status of Cash Reserve Account Report.* The specifics of this quarterly report are detailed in Addendum III.B(5), *Reporting*, (page 101). This report is due 30 days after the end of each quarter.

6. *Performance Improvement Project Executive Summary Reports.* The specifics of this report are detailed in Addendum VIII, *Performance Improvement Projects* (page 111).

7. *Complaint and Grievance Report.* The specifics of this report are detailed in Article IV.K, *Documentation and Reporting*, (3) (page 38).

8. *Annual Audit.* The specifics of this audit are in Article VII.I, *Annual Audit* (page 65).

9. *Business Plan.* The specifics of this plan are detailed in Article VII.A(2), *Business Plan* (page 58).

10. *CMO Quality Indicators.* The specifics regarding this data and timeframes are in Addendum II, *CMO Quality Indicators* (page 94).

C. Reports: As Needed

The CMO agrees to furnish reports to the Department, and to the Department's authorized agents, which the Department may require to administer this contract, that are specific to certain events. Such reports include but not limited to the following:

1. *Personal Injury Settlements.* When the CMO is aware of personal injury case settlements, the CMO shall submit any information regarding such settlement to the Department as soon as practical. The CMO shall use the form attached in Addendum VII, *Medicaid CMO Personal Injury Settlements* (page 110), for reporting these settlements.

2. *Reporting of Corporate and Other Changes.* If corporate restructuring or any other change affects the continuing accuracy of certain information previously reported by the CMO to the Department, the CMO shall report the change in information to the Department. The CMO shall report each such change in information as soon as possible, but not later than 30 days after the effective date of the change. Changes in information covered under this section include all of the following:

    a. Any change in information relevant to Article VII.F, *Ineligible Organizations* (page 64).

    b. Any change in information relevant to *Provider Network and Subcontracts*, Article V.B(11)(c) (page 45).

D. Disclosure

The CMO and any subcontractors shall make available to the Department, the Department's authorized agents, and appropriate representatives of the U.S. Department of Health and Human Services any financial records of the CMO or subcontractors which relate to the CMO's capacity to bear the risk of potential financial losses, or to the services performed and amounts paid or payable under this contract. The CMO shall

comply with applicable record-keeping requirements specified in HFS 105.02(1)-(7) Wis. Adm. Code, as amended.

E. Records Retention

The CMO shall retain, preserve and make available upon request all records relating to the performance of its obligations under this contract, including claim forms, for a period of not less than five years from the date of termination of this contract. Records involving matters which are the subject of litigation shall be retained for a period of not less than five years following the termination of litigation. Electronic copies of the documents contemplated herein may be substituted for the originals with the prior written consent of the Department, provided that the electronic storage format is approved by the Department as reliable and is supported by an effective retrieval system.

Upon expiration of the five-year retention period, the CMO may request authority from the Department to destroy, dispose of or transfer the records identified directly above. The CMO shall retain such records until it receives written approval from the Department.

XI. Remedies for Violation, Breach, or Non-Performance of Contract

A. Suspension of New Enrollment

Whenever the Department determines that the CMO is out of compliance with this contract, the Department may suspend the CMO 's right to receive new enrollment under this contract. The Department, when exercising this option, must notify the CMO in writing of its intent to suspend new enrollment at least 30 days prior to the beginning of the suspension period. The suspension will take effect if the non-compliance remains uncorrected at the end of this period. The Department may suspend new enrollment sooner than the time period specified in this paragraph if the Department finds that member long term care, health or welfare is jeopardized. The suspension period may be for any length of time specified by the Department, or may be indefinite. The suspension period may extend up to the expiration of the contract as provided under Article XVII, *CMO Specific Contract Terms* (page 86).

The Department may also notify members of CMO non-compliance and inform them of their ability to disenroll from the CMO.

B. Department-Initiated Enrollment Reductions

The Department may reduce the maximum enrollment level and/or number of current members whenever it determines that the CMO has failed to provide one or more of the services necessary to achieve outcomes in the LTC benefit package required under Article III.A, *Provision of Services in the LTC Benefit Package* (page 14) or that the CMO has failed to maintain or make available any records or reports required under this contract which the Department needs to determine whether the CMO is providing the services as required under Article III.A. The CMO shall be given at least 30 days to correct the non-compliance prior to the Department taking any action set forth in this paragraph. The Department may reduce enrollment sooner than the time period specified

in this paragraph if the Department finds that member long term care, health or welfare is jeopardized.

C. Other Enrollment Reductions

The Department may also suspend new enrollment or disenroll members in anticipation of the CMO not being able to comply with Federal or State law at its current enrollment level. Such suspension shall not be subject to the 30 day notification requirement.

D. Withholding of Per Member Per Month Payments and Orders to Provide Services

Notwithstanding the provisions of Article IX, *Payment to CMO* (page 70), the Department may withhold portions of per member per month payments as liquidated damages or otherwise recover damages from the CMO on the following grounds:

1. Whenever the Department determines that the CMO has failed to provide one or more of the services necessary to achieve outcomes in the LTC benefit package, required under Article III.A, *Provision of Services in the LTC Benefit Package* (page 14), the Department may either order the CMO to provide such service, or withhold a portion of the CMO's per member per month payments for the following month or subsequent months, such portion withheld to be equal to the amount of money the Department must pay to provide such services.

   When the Department withholds payments under this section, the Department must submit to the CMO a list of the members for whom payments are being withheld, the nature of the service(s) denied, and payments the Department must make to provide the services necessary to achieve outcomes.

   If the Department acts under this section and subsequently determines that the services in question were not covered services:

   a. In the event the Department withheld payments, it shall restore to the CMO the full per member per month payment; or

   b. In the event the Department ordered the CMO to provide services under this section, it shall pay the CMO the actual documented cost of providing the services.

2. If the CMO fails to submit required data and/or information to the Department or the Department's authorized agents, or fails to submit such data or information in the required form or format, by the deadline specified by the Department, the Department may immediately impose liquidated damages in the amount of $100 per day for each day beyond the deadline that the CMO fails to submit the data or fails to submit the data in the required form or format, such liquidated damages to be deducted from the CMO's per member per month payments.

3. Whenever the Department determines that the CMO has failed to perform an administrative function required under this contract, the Department may withhold a portion of future per member per month payments. For the purposes of this section,

"administrative function" is defined as any contract obligation other than the actual provision of contract services. The amount withheld by the Department under this section will be an amount that the Department determines in the reasonable exercise of its discretion to approximate the cost to the Department to perform the function. The Department may increase these amounts by 50% for each subsequent non-compliance.

4. Whenever the Department determines that the CMO has failed to perform the administrative functions defined in Article IX.F, *Third Party Liability (TPL)* (page 71), the Department may withhold a portion of future per member per month payments sufficient to directly compensate the Department for the Medicaid program's costs of providing services and items to members insured by said insurers and/or the insurers/employers represented by said third party administrators.

5. In any case under this contract where the Department has the authority to withhold per member per month payments, the Department also has the authority to use all other legal processes for the recovery of damages.

E. Inappropriate Payment Denials

CMOs that inappropriately fail to provide or deny payments for services may be subject to suspension of new enrollments, withholding, in full or in part, per member per month payments, contract termination, or refusal to contract in a future time period, as determined by the Department. The Department will select among these sanctions based upon the nature of the services in question, whether the failure or denial was an isolated instance or a repeated pattern or practice, and whether the long term care or health of a member was injured, threatened or jeopardized by the failure or denial. This applies not only to cases where the Department has ordered payment after appeal, but also to cases where no appeal has been made (i.e., the Department is knowledgeable about the documented abuse from other sources).

F. Appointment of Temporary Management

The Department has the option to appoint temporary management of the CMO under the following circumstances:

- The CMO repeatedly fails to meet the requirements of this contract;
- There is substantial risk to the health of the CMO's members; or
- There is a need to assure the health of the CMO's members during an orderly termination or reorganization of the CMO or improvements are being made to correct violations of this contract.

Temporary management will not be removed until the Department determines the CMO has the capability to ensure the violations will not recur.

G. Contract Termination

The Department may terminate this contract as specified in Article XII, *Termination, Modification and Renewal of Contract* (page 79).

H. Authority of the Secretary

Section 1903(m)(5)(B)(ii) of the Social Security Act vests the Secretary of the Department of Health and Human Services with the authority to deny Medicaid payments to a CMO for members who enroll after the date on which the CMO has been found to have committed one of the violations identified in the Federal law. State payments for members of the CMO are automatically denied whenever, and for so long as, Federal payment for such members has been denied as a result of the commission of such violations.

I. Authority of the Department

The Department may pursue all sanctions and remedial actions with the CMO that are taken with Medicaid fee-for-service providers.

XII. Termination, Modification and Renewal of Contract

A. Modification

This contract may be modified at any time by written mutual consent of the CMO and the Department or when modifications are mandated by changes in Federal or State laws, and amendments to Wisconsin's HCFA approved waivers: #0154.90.R1; #0229.90.04; #0297.02; and #0275.90. In the event that changes in State or Federal law require the Department to modify its contract with the CMO, notice shall be made to the CMO in writing. However, the per member per month payment rate to the CMO can be modified only as provided in Article IX.C, *Payment to CMO* (page 70), relating to Renegotiation.

If the Department exercises the right to renew this contract, the Department will recalculate the per member per month payment rate for succeeding calendar years. The CMO shall have 60 days to accept the new per member per month payment rate in writing or to initiate termination of the contract. If the Department changes the reporting requirements during the term of this contract, the CMO shall have 180 days to comply with such changed requirements or to initiate termination of the contract.

B. Mutual Consent of Termination

This contract may be terminated at any time by mutual consent of both the CMO and the Department.

C. Unilateral Termination

This contract between the parties may be unilaterally terminated only as follows:

1. This contract may be terminated at any time, by either party, due to modifications mandated by changes in Federal or State law, regulations, or policies that materially affect either party's rights or responsibilities under this contract. In such case, the party initiating such termination procedures must notify the other party, at least six months prior to the proposed date of termination, of its intent to terminate this contract. Termination by the Department under these circumstances shall impose an obligation upon the Department to pay the CMO's reasonable and necessarily incurred termination expenses.

2. This contract may be terminated by either party at any time if it determines that the other party has substantially failed to perform any of its functions or duties under this contract. In such event, the party exercising this option must notify the other party, in writing, of this intent to terminate this contract and give the other party 30 days to correct the identified violation, breach or non-performance of contract. If such violation, breach or non-performance of contract is not satisfactorily addressed within this time period, the exercising party must notify the other party, in writing, of its intent to terminate this contract at least six months prior to the proposed termination date. The termination date shall always be the last day of a month. The contract may be terminated by the Department sooner than the time period specified in this paragraph if the Department finds that member long term care, health or welfare is jeopardized by continued enrollment in the CMO. A "substantial failed to perform" for purposes of this paragraph includes any violation of any requirement of this contract that is repeated or on-going, that goes to the essentials or purpose of the contract, or that injures, jeopardizes or threatens the long term care, health, safety, welfare, rights or other interests of members, the CMO's failure to meet performance criteria of this contract, and the CMO's failure to meet the target enrollment levels, as specified in Article XVII, *CMO Specific Contract Terms* (page 86).

3. This contract may be terminated by either party, in the event Federal or State funding of contractual services rendered by the CMO become or will become permanently unavailable. In the event it becomes evident State or Federal funding of claims payments or contractual services rendered by the CMO will be temporarily suspended or unavailable, the Department shall immediately notify the CMO, in writing, identifying the basis for the anticipated unavailability or suspension of funding. Upon such notice, the Department or the CMO may suspend performance of any or all of the CMO's obligations under this contract if the suspension or unavailability of funding will preclude reimbursement for performance of those obligations. The Department or CMO shall attempt to give notice of suspension of performance of any or all of the CMO's obligations by 60 days prior to said suspension, if this is possible; otherwise, such notice of suspension should be made as soon as possible. In the event funding temporarily suspended or unavailable is reinstated, the CMO may remove suspension hereunder by written notice to the Department, to be made within 30 days from the date the funds are reinstated. In the event the CMO elects not to reinstate services, the CMO shall give the Department written notice of its reasons for such decision, to be made within 30 days from the date the funds are reinstated. The CMO shall make such decision in good faith and will provide to the Department documentation supporting its decision. In the event of termination under this section, this contract shall terminate without termination costs to either party.

D. Contract Non-Renewal

The CMO or the Department may decide to not renew this contract. In the case of a non-renewal of this contract the party deciding to not renew this contract must notify the other party at least six months prior to the expiration date of this contract, and following the procedure in E and F in this Article.

E. Transition Plan

In the case of this contract being terminated or a decision to not renew this contract, the CMO shall submit a plan, that receives the Department's approval, to ensure uninterrupted delivery of services to CMO members and their successful transition to applicable programs (e.g. Medicaid fee for service, Community Options Program, Community Integration Program). The plan will include provisions for the transfer of all member related information held by the CMO or its providers and not also held by the Department.

1. *Submission of the Transition Plan.* The CMO shall submit the plan at one of the following times, depending on which applies: no less than 120 days prior to the contract's expiration when the CMO decides to not renew the contract; within 10 business days of notice of termination by the Department; or along with the CMO's notice of termination.

2. *Management of the Transition.* The CMO shall designate a person responsible for coordinating the transition plan and will assign staff as the Department determines is necessary to assist in the transition. Status meetings including staff from all parties involved in the transition will be held as frequently as the Department determines is necessary.

3. *Continuation of Services.* If the CMO has been unable to successfully transition all members to applicable programs by the time specified in the approved transition plan, the CMO shall continue operating as a CMO under this contract until all members are successfully transitioned. The Department will determine when all members have been successfully transitioned to applicable programs.

   If the Department determines it necessary to do so, the CMO will agree to extend this contract, in order to continue providing services to members until they are successfully transitioned to applicable programs. During this period the CMO remains responsible, and shall provide, the services in the LTC benefit package, and all terms and conditions of the contract will apply during this period.

F. Obligations of Contracting Parties

When termination or non-renewal of this contract occurs, the following obligations shall be met by the parties:

1. The Department shall be responsible for notifying all members of the date of termination and process by which the members continue to receive services in the LTC benefit package;

2. The CMO shall be responsible for all expenses related to said notification;

3. Any payments advanced to the CMO for coverage of members for periods after the date of termination or expiration shall be returned to the Department within 45 days;

4. The CMO shall promptly supply all information necessary for the reimbursement of any outstanding Medicaid claims; and

5. Recoupments will be handled through a payment by the CMO within 90 days of the end of this contract.

XIII. Cooperation of Parties and Dispute Resolution

The Department has the right to final interpretation of this contract language when disputes arise.

The parties agree to fully cooperate with each other in connection with the performance of their respective obligations and covenants under this contract.

The parties shall use their best efforts to cooperatively resolve disputes and problems that arise in connection with this contract. When a bona fide dispute arises between the CMO and the Department which cannot be resolved, the sole and exclusive method of resolving the dispute shall be the following process:

- For any audit dispute, review will be through the audit resolution process.

- For all other disputes, either party may request a review with the Director of the Office of Strategic Finance, and then with the Department's Deputy Secretary if the dispute is still remaining after the Director's review. The existence of a dispute notwithstanding, both parties agree to continue without delay to carry out all their respective responsibilities which are not affected by the dispute and the CMO further agrees to abide by the interpretation of the Department regarding the matter in dispute while the CMO seeks further review of that interpretation.

XIV. Confidentiality of Records

The CMO agree that all information, records, and data collected in connection with this contract shall be protected from unauthorized disclosure as provided in Ch. 46, Subchapter II, Wis. Stats., HFS 108.01, Wis. Admin. Code, and 42 CFR 431 Subpart F. Except as otherwise required by law, access to such information shall be limited by the CMO and the Department to persons who, or agencies which, require the information in order to perform their duties related to this contract, including the U.S. Department of Health and Human Services and such others as may be required by the Department.

The CMO shall have written confidentiality policies and procedures in regard to confidential member information. Policies and procedures must be communicated to the CMO staff, members, and providers. The transfer of member records to non-CMO providers or other agencies not affiliated with the CMO are contingent upon the receipt by the CMO of written authorization to release such records signed by the member or by the member's authorized representative.

The CMO agrees to forward to the Department all media contacts regarding members or the Medicaid program.

XV. Documents Constituting Contract

The contract between the CMO and the Department shall include, in addition to this contract, Medicaid Provider Bulletins addressed to the CMO and the CMO Contract Interpretation Bulletins issued pursuant to this contract. In the event of any conflict in provisions among these documents, the terms of this contract shall prevail. In addition, the contract shall incorporate the following Addenda:

I. Definitions;
II. CMO Quality Indicators;
III. Solvency Protection Requirements;
IV. Reporting;
V. Third Party Liability (TPL) Report Format;
VI. Actuarial Basis;
VII. Medicaid CMO Personal Injury Settlements;
VIII. Performance Improvement Projects.

The documents listed above constitute the entire contract between the CMO and the Department and no other expression, whether oral or written, constitutes any part of this contract.

XVI. Miscellaneous

A. Delegations of Authority

No delegations of authority are permitted under this contract.

B. Indemnification

The CMO agrees to defend, indemnify and hold the Department harmless, with respect to any and all claims, costs, damages and expenses, including reasonable attorney's fees, which are related to or arise out of the CMO's negligence or willful conduct, including, but not limited to the following:

1. Any failure, inability, or refusal of the CMO or any of its subcontractors to provide services in the LTC benefit package;

2. The negligent provision of services in the LTC benefit package by the CMO or any of its subcontractors;

3. Any failure, inability or refusal of the CMO to pay any of its subcontractors for services in the LTC benefit package; or

4. Any violation of confidentiality requirements.

C. Independent Capacity of the CMO

The Department and the CMO agree that the CMO and any agents or employees of the CMO, in the performance of this contract, shall act in an independent capacity, and not as officers or employees of the Department.

D. Omissions

In the event that the CMO or the Department hereto discovers any material omission in the provisions of this contract which such party believes is essential to the successful performance of this contract, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this contract, or shall pursue the arbitration process available under Article XIII, *Cooperation of Parties and Dispute Resolution* (page 82).

E. Choice of Law

This contract shall be governed by and construed in accordance with the laws of the State of Wisconsin. The CMO shall be required to bring all legal proceedings against the Department in the State courts in Dane County, Wisconsin.

F. Waiver

No delay or failure by the CMO or the Department hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained.

G. Severability

If any provision of this contract is declared or found to be illegal, unenforceable, invalid or void, then both parties shall be relieved of all obligations arising under such provision; but if such provision does not relate to payments or services to members and if the remainder of this contract shall not be affected by such declaration or finding, then each provision not so affected shall be enforced to the fullest extent permitted by law.

H. Force Majeure

The CMO and the Department shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this contract as a result of a catastrophic occurrence or natural disaster including but not limited to an act of war, and excluding labor disputes.

I. Headings

The article and section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

J. Assignability

Except as allowed under subcontracting, this contract is not assignable by the CMO either in whole or in part, without the prior written consent of the Department.

K. Right to Publish

The Department agrees to allow the CMO to write and have such writings published provided the CMO receives prior written approval from the Department before publishing writings on subjects associated with the work under this contract. The CMO agrees to protect the privacy of individual members, as required under 42 CFR Part 434.6(a)(8).

XVII. CMO Specific Contract Terms

County(ies) in which enrollment is accepted: _____

Per Member Per Month Payment Rate: Monthly per member per month payment rate for each member at the "intermediate" level of care: $_____. Monthly per member per month payment rate for each member at the "comprehensive" level of care: $_____.

For members who are functionally eligible through the grandfathering provision, and not functionally eligible at the comprehensive or intermediate level of care, the CMO will be paid through a mechanism developed by the Department. (See the definition of "eligibility" in Addendum I, *Definitions,* beginning page 87, regarding grandfathering provision). The Department will also provide specifications about the services in the LTC benefit package for this group of people.

THIS CONTRACT SHALL BECOME EFFECTIVE ON _____, 2000, AND SHALL EXPIRE ON DECEMBER 31, 2000, UNLESS TERMINATED EARLIER.

In WITNESS WHEREOF, the State of Wisconsin and _____ County have executed this contract:

FOR CMO:	FOR STATE:
BY: _____ (name) _____ (title)	BY: Charles Wilhelm, Director Office of Strategic Finance
DATE:	DATE:

Addenda

I. Definitions

Adult Protective Services/APS/Persons in need of Adult Protective Services—a person in need of Adult Protective Services (APS) is an individual age 18 and over who meets both of the following criteria:

1. A physical or mental condition which substantially impairs the ability of the person to adequately care for his/her needs; and

2. Is experiencing, or is at risk of experiencing, abuse, financial exploitation, neglect, or self-neglect. At risk means that there is reasonable cause to believe that abuse, financial exploitation, neglect, or self-neglect will occur.

The following terms used in the APS definition shall have the following meaning:

- Abuse may include any of the following:
  - Physical abuse means the willful or reckless infliction of bodily harm. Bodily harm means physical pain or injury, illness, or any impairment of physical condition.
  - Sexual abuse is sexual conduct in the first through fourth degrees as defined in s. 940.225 Wis. Stats.
  - Emotional abuse is language or behavior which is intimidating, humiliating, threatening, frightening or otherwise harassing.

- Treatment without consent means the administration of medication to a person who has not provided informed consent, or the performance of psychosurgery, electroconvulsive therapy or experimental research on a person who has not provided informed consent, with the knowledge that no lawful authority exists for the administration or performance.

- Unreasonable confinement or restraint includes, but is not limited to, the unreasonable use of a locked room, involuntary separation, or physical restraining devices, or the unnecessary or excessive use of medication. Use of such methods or devices may be reasonable, if employed in conformance with State and Federal standards governing confinement and restraint.

- Financial Exploitation means obtaining a person's money or property by deceiving or enticing the person, or by forcing, compelling, or coercing the person to give, sell at less than fair market value, or in other ways convey money or property against his or her will or without his or her informed consent. It also includes taking, carrying away, using, transferring, concealing or retaining possession of a person's money or property without the person's informed consent.

Financial exploitation further includes the substantial failure or neglect of a fiscal agent to fulfill his or her responsibilities, resulting in harm or substantial risk of harm to the person to whom the fiscal agent is responsible. Fiscal agents include, but are not limited to: guardians of estates appointed under s. 880.33 Wis. Stats.; conservators appointed under s. 880.31 Wis. Stats.; agents under a financial power of attorney under s. 243.07 Wis. Stats.; representative payees under 20 CFR Ch.III s. 416.635 (March 1, 1997 edition); conservatorships under the Veteran's Affairs Administration (Federal Uniform Benefit Act) and trustees.

- Neglect means the failure of a caregiver to provide or obtain adequate care, services, or supervision including, but not limited to food, clothing, shelter, or physical or mental health care which creates significant risk or danger to a person's physical or mental health. Neglect does not include a decision made not to seek medical care, if that decision is consistent with a previously executed health care advance directive under Chs. 154 or 155, Wis. Stats., or as otherwise authorized by law.

  A caregiver is an individual who has assumed responsibility for all or a portion of a person's care, voluntarily, by contract, or by agreement including a person acting or claiming to act as a legal representative.

- Self-neglect means a significant risk or danger to a person's physical or mental health because the person is responsible for his or her own care but fails to obtain adequate care or services including, but not limited to food, clothing, shelter, or medical or dental care.

Advance Directive—a written instruction, such as a living will or durable power of attorney for health care, recognized under Wisconsin law (whether statutory or recognized by the courts of Wisconsin) and relating to the provision of such care when the individual is incapacitated.

Aging and Disability Resource Center/Resource Center—an organization contracting with the Department to provide access to information and assistance, community resources and publicly funded long term care services for elderly people, people with disabilities, and the public. The Resource Center also determines functional and financial eligibility for Family Care and conducts the enrollment process for CMO members.

Care Management/Case Management—the service whereby the care management team, in partnership with the member, conducts a comprehensive assessment of the member's long term care needs, capacities, and preferences, and the supportive capacity of the living environment and the community. The service also includes planning, authorizing, arranging, coordinating and monitoring appropriate services, resources and supports to meet the individual member's needs and to achieve planned outcomes.

Care Management Organization/CMO—a pre-paid health plan entity, as defined in CFR 434.2, which provides long term care and health care services to enrolled members, under contract with the State Medicaid agency and on the basis of prepaid capitation fees. Besides providing long term care and health care services as defined in this contract, the CMO also coordinates other services its members receive, and promotes preventive health services. In this

contract, CMO means _____ County's Care Management Organization, that is obligated under this contract, and that operates in _____ County.

Cash Reserve—a segregated fund account that the CMO establishes to ensure continuity of care for its members, accountability to taxpayers, solvency protection against financially catastrophic cases, and effective program administration.

Complaint—any oral or written communication made by or on behalf of a member to any CMO employee or a CMO provider or to the Department expressing dissatisfaction with any aspects of the CMO or CMO provider's operations, activities, or behaviors regardless of whether the communication requests any remedial action.

Contract/This Contract/Health and Community Supports Contract—this contractual agreement between the Department of Health and Family Services and the CMO and its addenda, which is a Pre-Paid Health Plan (PHP).

Days—unless otherwise specified in the contract (e.g., "business days"), days shall mean calendar days.

Department—the Wisconsin Department of Health and Family Services.

Eligibility—

As of the effective date of this contract:

To be eligible to enroll in the CMO, an individual must meet all five of the following criteria:

Note: Customize for target population served.

1. Meets general age and disability requirements, which consist of:
   - At least 18 years old, and
   - A physical disability as defined in s. 15.197 (4)(a) Wis. Stats., or
   - Infirmities of aging as defined in s. 55.01 (3) Wis. Stats., or
   - Developmental disability as defined in s. 51.01 (5)(a) Wis. Stats., or as defined federally in P.L. 95-602 and;

2. Is eligible for Medicaid and;

3. Is functionally eligible under one of the following conditions:
   - Meets comprehensive level criteria; or
   - Meets intermediate level criteria; or
   - Meets intermediate level criteria and is determined to be in need of adult protective services; or
   - Is eligible because of grandfathering provisions, which consist of:

     The individual has a condition expected to last at least 90 days or result in death within one year after the date of application for CMO enrollment and, on the effective date of this contract, the person was a resident in a nursing home or had been receiving long term care services for at least 60 days, under a written plan of care that were funded under any of the following:
     - Community Options Program (COP),

- A Home and Community-Based Waiver Program (e.g., the Community Integration Programs),
- Alzheimer's Family Caregiver Support Program,
- Community Aids, or
- County funding and;

4. Is a resident of the county served by the CMO; and

5. The individual desires to enroll in the CMO, as indicated by signing the Enrollment Request.

As of July 1, 2000 or upon notification from the Department:
To be eligible to enroll in the CMO, an individual must meet all five of the following criteria:

1. Meets general age and disability requirements, which consist of:
   - At least 18 years old, and
   - A physical disability as defined in s. 15.197(4)(a) Wis. Stats., or
   - Infirmities of aging as defined in s. 55.01(3) Wis. Stats., or
   - A developmental disability as defined in s. 51.01(5)(a) Wis. Stats., or as defined federally in P.L. 95-602 and;

Note: Customize for target population served.

2. Is financially and non-financially eligible under one of the following conditions:
   - Eligible for Medicaid, or
   - The individual would qualify for Medicaid, as specified in HFS 103.03 Wis. Admin. Code, and the projected cost of the person's individual service plan, as calculated by the Department or its designee, exceeds the individual's gross monthly income, plus one-twelfth of his or her countable assets, less deductions and allowances permitted by rule by the Department and;

3. Is functionally eligible under one of the following conditions:
   - Meets comprehensive level criteria; or
   - Meets intermediate level criteria and is eligible for Medicaid; or
   - Meets intermediate level criteria and is determined to be in need of adult protective services; or
   - Is eligible because of grandfathering provisions, which consist of:

     Individual has a condition expected to last at least 90 days or result in death within one year after the date of application for CMO enrollment and, on the effective date of this contract, the person was a resident in a nursing home or had been receiving long term care services, for at least 60 days, under a written plan of care that were funded under any of the following:
     - Community Options Program (COP),
     - A Home and Community-Based Waiver Program (e.g., the Community Integration Programs),
     - Alzheimer's Family Caregiver Support Program,

- Community Aids, or
- County funding and;

4. Is a resident of the county served by the CMO; and

5. The individual desires to enroll in the CMO, as indicated by signing Enrollment Request.

Grievance—a written communication submitted by or on behalf of a member expressing dissatisfaction with any aspect of the CMO's or CMO provider's operations, activities, or behaviors that pertain to: 1) the availability, delivery or quality of long term care or health care services, including service authorization decisions that are adverse to the member; 2) payment, treatment or reimbursement of claims for long term care and health care services; or 3) issues unresolved through the complaint process.

Long Term Care Benefit Package/LTC Benefit Package—services provided by the CMO directly or through other providers for which the Department makes a per member per month payment to the CMO.

Marketing/Outreach Activities—the production and dissemination of marketing/outreach materials and the sponsorship of community events that can be reasonably interpreted as intended to influence individuals to enroll or reenroll in the CMO.

Marketing/Outreach Materials—materials in all mediums, including but not limited to, internet, brochures and leaflets, newspaper, magazine, radio, television, billboards, yellow pages, advertisements, other print media and presentation materials, used by or on behalf of the CMO to communicate with individuals who are not members, and that can be reasonably interpreted as intended to influence the individuals to enroll or reenroll in the CMO.

Medicaid—the Wisconsin Medical Assistance program operated by the Wisconsin Department of Health and Family Services under Title XIX of the Federal Social Security Act, Ch. 49, Wis. Stats., and related State and Federal rules and regulations. The term "Medicaid" will be used consistently in the contract. However, "Medicaid" is also known as "MA," "Medical Assistance," and "WMAP."

Member—a person who meets the eligibility criteria and has signed an Enrollment Request.

Recipient—any individual entitled to benefits under Title XIX of the Social Security Act, and under the Medicaid State Plan as defined in Chapter 49, Wis. Stats.

Risk— the result of the CMO's agreement with the Department to provide the membership with a range of services for a fixed sum per member per month payment. The CMO assumes a degree of financial risk to provide services within the set dollar amount.

Risk Sharing Mechanism—the terms under which the Department and the CMO shall share in the CMO's operating losses as described in Addendum II, *CMO Quality Indicators* (page 94).

Service Area— the geographic area within which potential members must reside in order to enroll and remain enrolled in the CMO under this contract. Potential members shall be residents

of the county (or one of the counties) listed in Article XVII, *CMO Specific Contract Terms*, page 86.

Services Necessary to Achieve Outcomes—services necessary to achieve outcomes identified in the member's Individual Service Plan include both "necessary long term care services" and "medically necessary services." The CMO can offer reasonable alternative services that meet a member's needs and desired outcomes at less expense. Reasonable alternatives are those which: (1) have been effective for persons with similar needs; and (2) would not have significant negative impact on desired outcomes.

Necessary Long Term Care Services and Supports—include any service or support that is provided to assist a member complete daily living activities, learn new skills, maintain a general sense of safety and well-being, or otherwise pursue a normal daily life rhythm, and that meets the following standards:

- Is consistent with the member's comprehensive assessment and Individual Service Plan;
- Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;
- Is appropriate with regard to Department's and CMO's generally accepted standards of long term care and support;
- Is not duplicative with respect to other services being provided to the member;
- With respect to prior authorization of a service and other prospective coverage determinations made by the CMO, is cost-effective compared to an alternative necessary long term care service which is reasonably accessible to the member; and
- Is the most appropriate supply or level of service that can safely and effectively be provided to the member.

Medically Necessary Services—are Medicaid services (as defined under s. 49.46 Wis. Stats. and ch. Wis Admin. Code 107) that are required to prevent, identify or treat a member's illness, injury or disability; and that meet the following standards:

- Is consistent with the member's symptoms or with prevention, diagnoses or treatment of the member's illness, injury or disability;
- Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;
- Is appropriate with regard to generally accepted standards of medical practice;
- Is not medically contraindicated with regard to the member's diagnoses, symptom, or other medically necessary services being provided to the member;
- Is of proven medical value or usefulness and, consistent with s. HSS 107.035, is not experimental in nature;
- Is not duplicative with respect to other services being provided to the member;
- Is not solely for the convenience of the member, the member's family or a provider;
- With respect to prior authorization of a service and other prospective coverage determinations made by the Department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the member; and
- Is the most appropriate supply or level of service that can safely and effectively be provided to the member.

Subcontract—any written agreement between the CMO and another party for services in the LTC benefit package, and other products and services provided to the CMO.

Subcontractor/CMO Provider—a service provider the CMO has an agreement with for providing services to CMO's members.

II. CMO Quality Indicators

This addendum lists the quality indicators the CMO will report data directly to the Department. All but one piece of information will be reported on the monthly HSRS report. One piece of information, the turnover rate of care management staff, will be reported annually by the CMO.

One of these indicators is built on a combination of CMO data reported on HSRS and from consumer interviews/surveys, and/or administrative/clinical audits, both performed by the Department or its agent.

Focus Area	Self Determination & Rights
Consumer Outcome	• People are treated fairly (exercise their rights free from coercion or retribution). • People have personal dignity and respect.
Quality Indicator	Percent of members who voluntarily disenroll and transfer to Medicaid fee-for-service or the COP/waiver program.
Population Groupings	Stratify by target population and age.
Performance Measure	Numerator 1: Number of members who disenroll voluntarily (which is reported in HSRS field 24 – SPC 802, sub-codes 51, 52) and transfer to Medicaid fee-for-service or one of the COP/waiver programs. Denominator 1: All members who disenroll in the CMO (i.e. total members with a code in HSRS field 24 – SPC 802 with any disenrollment sub-code). Numerator 2: Same as numerator 1. Denominator 2: Total CMO enrollment.
Data Source	HSRS
Data Elements	Client demographics (i.e. Client LN, FN, MI, Medicaid number, SSN, client ID, DOB, special project status, and county), program eligibility date, episode end date, CMO disenrollment SPC
Timeframe	Contract period (however, this indicator will be more meaningful when trended over two or more contract periods). Point in time measurement. (An example of a point in time measurement would be all members who were enrolled in the CMO as of December 31 of the preceding year who were not enrolled as of December 31 of the reporting year.)

Focus Area	Self determination & Rights
Consumer Outcome	• People choose their services.
Quality Indicator	Percent of members who have used paid staff for help at home who report that they chose or hired the paid staff who help him/her at home (e.g., personal care worker, supportive care workers).
Population Groupings	Stratify by target population and age.
Performance Measure	Numerator: Members whose in-home supportive care services are provided by an individual of their own choosing. This information will be obtained via a member survey/interview or audit, both of which would be conducted by the Department or its agent. Denominator: Any member who has used in-home supportive care services. Use HSRS database to identify the denominator (SPC 104 with any of the following sub-codes 10, 11, 12, 13, 14, 20, 21, 22, 23, 24).
Data Source	• HSRS • Self-reported member survey or interview, conducted by Department or its agent, or • Data gathered during Department audit of CMO.
Data Elements	Client demographics, program eligibility date, SPC code for supportive home care worker.
Timeframe	Contract period

Focus Area	Self determination & Rights
Consumer Outcome	• People choose their services. • People choose their daily routine.
Quality Indicator	Percent of members choosing some level of self-directed supports. (Risk adjustment issues should be considered with this indicator.
Population Groupings	Stratify by target population and age.
Performance Measure	Numerator: Number of members with SPC 609 Consumer Directed Supports Denominator: Total number of members enrolled
Data Source	HSRS
Data Elements	Client demographics, program eligibility date, SPC code
Timeframe	Contract period. Point in time measurement.

Focus Area	Self determination & Rights
Consumer Outcome	• People achieve their employment objectives. • (People receiving vocational supports find and maintain employment in integrated settings and earn increased wages).
Quality Indicator	Percent of members whose current and principal employment setting is sheltered workshop, prevocational work sites, or supported employment settings.
Population Groupings	Stratify by target population and age.
Performance Measure	Numerator: Number of members who are employed by category – SPC 108 (prevocational & sheltered work sites), 615 (supported employment). (This numerator does not count members who are independently employed without supports). Denominator: Total members who are working (this number is obtained from the LTC Functional Screen Module II Field L).
Data Source	• HSRS • LTC Functional Screen
Data Elements	Client demographics, program eligibility date, SPC code
Timeframe	Contract period. Point in time measurement.

Focus Area	Community Integration & Social Roles
Consumer Outcome	• People choose where and with whom to live.
Quality Indicator	Percent of members who are relocated into the community from an institutional setting.
Population Groupings	Stratify by target population, gender and age.
Performance Measure	Numerator 1: Number of members whose prior location was a general nursing home, ICF/MR, or brain injury rehab unit (field 13, N, F, & B) Denominator 2: Total number of members enrolled Numerator 2: Same as above Denominator 2: Total number of members residing in an institution
Data Source	HSRS
Data Elements	Client demographics, gender, program eligibility date, HSRS field 13
Timeframe	Contract period

Focus Area	Community Integration & Social Roles
Consumer Outcome	• People choose where and with whom they live. • People participate in the life of the community. • People remain connected to informal support networks.
Quality Indicator	Current member living arrangement. a) Percent living in natural settings (e.g., Own home or apartment; Supervised Community Living); b) Percent living in regulated community settings (e.g., AFHs and CBRFs) categorized by size of setting as listed below); c) Percent living in institutional settings (e.g., ICF/MR, Center for Persons with Developmental Disabilities, nursing facility); d) Percent of members who have no permanent address.
Population Grouping	Stratify by target population, gender and age. (In addition to target population and age, this measure may be risk adjusted based on functional status to indicate key differences between people who receive LTC services and reside in certain settings).
Performance Measure	Numerator 1: Number of members currently residing in each of the following settings (as reported in HSRS field 11): • Own Home or Apartment (30); • Supervised Community Living (60); Numerator 2: Number of members currently residing in each of the following settings (as reported in HSRS field 11): • Adult Family Home, 1-2 beds (37). • Adult Family Home 3-4 beds (38); • CBRF, 5-8 beds (61); • CBRF, 9-15 beds (code to be determined); • CBRF, 16-20 beds (code to be determined); • CBRF, 21-50 beds (code to be determined); • CBRF, 51-99 beds code to be determined); • CBRF, 100 + beds (code to be determined); • CBRF, Independent Apartments (63); • Residential Care Apartment Complex (70). Numerator 3: Number of members currently residing in each of the following settings (as reported in HSRS field 11) • Developmental Disability Center (32); • ICF/MR (07); • Nursing Home (33); • Brain Injury Unit, Nursing Home (51). Numerator 4: Percent of members who have no permanent address (as reported in HSRS field 11 in the following setting: • No permanent address, or homeless shelter; (code to be

	determined). Denominator: Total members
Data Source	• HSRS
Data Elements	Client demographics, gender, program eligibility date, HSRS field 11

Focus Area	**Health & Safety**
Consumer Outcome	People experience continuity and security.
Quality Indicator	Percent of care management team members (i.e. social service coordinator and RN) who separated during the reporting period. Separation is defined as movement out of an organization (i.e., it includes resignations as well as terminations). Separations do not include transfers or promotions within an organization.
Population Grouping	None. (Care management team members are reported by provider type, i.e., social service coordinator, registered nurse).
Performance Measure	Numerator: Number of care management team members in the denominator who separated during the reporting year, i.e., who were not employed by the CMO as of December 31 of the reporting period (the numerator should include all care management team members regardless of why they separated, e.g., retired, etc.) Denominator: The total number of care management team members employed by the CMO as of December 31 of the year preceding the reporting year. Do not count the number of positions, e.g., if three different persons were employed in a particular position during the year, all three would be counted as part of the total number of care management team members. There are no exclusions from the denominator, i.e., all providers should be included whether they died, retired, were terminated or relocated during the reporting year.
Data Source	CMO data
Data Elements	Providers by name and provider type, effective date of employment, and termination date
Timeframe	Contract period. Point in time measurement.

III. Solvency Protection Requirements

A. General Requirements

1. The CMO shall provide solvency protections through a cash reserve, as provided in section (B), *Cash Reserve*, and through any other means acceptable to the Department, including without limitation, aggregate reinsurance, lines of credit or parent guarantees.

2. Except as otherwise provided in section (B), *Cash Reserve*, no later than the end of this contract period, the CMO shall have solvency protection equal to 15% of the projected CMO Revenue for the term of this contract, adjusted to 15% of actual CMO Revenue within 45 days following the independent audit for term of this contract. Projected CMO Revenue will be an amount calculated by the CMO and concurred in by the Department.

3. No later than the end of the first renewal period of this contract, the CMO shall have solvency protection equal to 15% of the projected CMO Revenue for the term of that contract period, adjusted to 15% of actual CMO Revenue within 45 days following the independent audit for that contract period. Projected CMO Revenue will be an amount calculated by the CMO and concurred in by the Department.

4. For purposes of this Addendum, CMO Revenue will mean all payments made by the Department to the CMO to provide services in the LTC Benefit Package to its members.

5. Subsections 1. and 2., above, do not apply during the period of this contract to a CMO operated by a county.

B. Cash Reserve

1. *Purpose*. The purpose of the cash reserve is to ensure continuity of care for enrolled members, accountability to taxpayers, solvency protection against financially catastrophic cases, and effective program administration.

2. *Cash Reserve Funds.* The CMO shall establish and maintain a separate depository or investment account to receive the contributions required under this section. The funds accumulated in this account are not to be intermingled with other funds of the CMO. Deposits to and withdrawals from such account are to be clearly identifiable within the accounting system and be supported by documentation of their compliance with (3) *Required Contributions* and (4) *Disbursements*, directly below.

   The cash reserve fund account is to be established through State or Federally licensed or chartered depository organizations in good standing. Within 30 days following the effective date of this contract, the CMO shall submit a specific cash reserve investment plan to the Department for approval if the funds will be placed in an investment account.

3. *Required Contributions*. The requirements under this subsection do not apply during the period of this contract to a CMO operated by a county.

    a. *Initial Contribution.* Within 30 days of receipt of the first per member per month payment under this contract, the CMO shall have on deposit in a cash reserve account an amount at least equal to 5% of the CMO Revenues, as projected by the CMO and concurred in by the Department, for the first three calendar months of enrollment. If the CMO does not meet this requirement, the Department may deduct from any CMO Revenues otherwise due the CMO an amount equal to the difference between the funds in the account and the funds required by this paragraph to be in the account. The Department shall deposit any deducted amounts into the CMO's cash reserve account.

    b. *Monthly Contribution.* By the end of each month beginning after the first month of enrollments, the CMO shall deposit an amount equal to 5% of CMO Revenues received during the prior month, up to the Minimum Balance required under (d) of this subsection, *Required Minimum Balance*.

    c. *Earnings.* Any income or gains generated by the cash reserve funds are to remain within the depository or investment account.

    d. *Required Minimum Balance.* The CMO may discontinue the monthly deposit under (b) of this subsection, *Monthly Contribution*, for any month in which the Minimum Balance is met at the beginning of the month. The Minimum Balance is an amount set for the term of each contract which is equal to one-twelfth of the annual CMO Revenue as projected by the CMO and concurred in by the Department. The projection shall be agreed upon between the CMO and the Department before the CMO discontinues the monthly deposits.

4. *Disbursements.* Once the Minimum Balance is met or when the Department allows, disbursements may be made from the cash reserve account in order to fund payments to the Department under risk sharing, fee-for-service savings and excess cost reimbursement if applicable, or to fund operating deficits. For any disbursements that are made to fund operating deficits, the following requirements apply:

    a. *Disbursement Notifications.* When the CMO withdraws or disburses funds that result in the balance falling below the Minimum Balance, the CMO shall notify the Department within ten days. Also, when the CMO withdraws or disburses $10,000 or more in the aggregate during any quarter, the CMO shall notify the Department no later than 45 days after the aggregate disbursement. Notifications shall include the amount and date of disbursement and indicate how the funds are to be replenished.

    b. *Plans for Replenishing Cash Reserve When Below Minimum*. The CMO shall have a plan, approved by the Department in its sole discretion, which specifies the methods and timetable the CMO shall employ to replenish the cash reserve fund if below the Minimum Balance. Failure to submit an acceptable plan to the

Department may subject the CMO to the remedies specified in Article XI, *Remedies for Violation, Breach, or Non-Performance of Contract* (page 76).

c. In approving or disapproving the plan, the Department will take into account existing or additional solvency protections available to the CMO.

5. *Reporting.* The CMO's agreement with the depository organization shall include a provision requiring submission to the Department of reports on the status of the cash reserve account. Reporting shall be quarterly for the term of this contract and the following contract renewal, and then annually thereafter.

C. Risk Sharing Arrangement

The Department will share risk of losses with the CMO as long as the CMO will share savings under this contract with the Department. The sharing of losses and savings will occur for the term of this contract, and will continue for each of the next two contract renewal years, unless the CMO elects to discontinue the sharing of risk and savings by notifying the Department prior to the beginning of a contract renewal year. The CMO may request sharing of losses and savings for contract renewal years after the CMO discontinued sharing or for years other than as provided here but it will be at the Department's sole discretion to approve the request and determine the manner of sharing. The CMO understands that it is the Department's intent to discourage risk sharing beyond three years.

1. *Sharing of Losses.* The Department will share losses with the CMO only after the CMO has expended all Family Care revenues, including all CMO revenues, enrollee cost share and third party liability recoveries, and after both individual stop/loss adjustments and retrospective payment adjustments are made. The Department will offer stop/loss protection for the high cost care of individual members once the cost of that care exceeds a threshold amount previously established by the CMO. For purposes of this section, losses are limited to losses attributable to service costs and are defined as a percentage of CMO Revenues, as calculated according to paragraph (a), below.

   a. *Computation of Losses.* The amount of losses subject to sharing shall be determined by an independent financial audit that is based on the CMO's financial reports required under Article X, *Reports and Data* (page 72) of this contract. To determine the losses eligible for sharing, actual administrative costs, up to a maximum allowable cost, will be deducted from CMO Revenues. The remainder amount will then be the base upon which the CMO's loss percentage is determined. 'Maximum allowable administrative costs' will equal 20% of CMO Revenues in the term of this contract, 15% of CMO Revenues for the first contract renewal year, and 10% of CMO Revenues for the second contract renewal year. The Department will provide a definition for "allowable administrative costs" for the purpose of sharing losses.

   b. *CMO Share of Losses.* The CMO shall have funds available to cover its portion of any losses. The CMO share of losses will be the cumulative total of its loss responsibilities under each loss corridor. The Department will offer aggregate

stop/loss insurance for the total cost of any losses above 10% of revenues, with specifications of the insurance policy determined by the CMO prior to the start of this contract period.

c. *Department Share of Losses.* The Department will share Medicaid losses with the CMO up to the upper payment limit imposed by 42 CFR 447.361. As required by the federal regulation, "under a risk contract, Medicaid payments to the contractor, for a defined scope of services to be furnished to a defined number of recipients, may not exceed the cost to the agency of providing those same services on a fee-for-service basis, to an actuarially equivalent non-enrolled population group." For non-Medicaid losses, the Department will share in 50% of the CMO's loss that falls in the second corridor, as shown in the table at the end of this Addendum.

2. *Sharing of Savings.* The CMO may retain savings only after the CMO complies with its obligations under this contract, including meeting performance expectations and any applicable solvency protections, and after it shares a portion of its savings with the Department if required under this contract. Except as provided in subsections b. and c., below, as part of the solvency protections that must be met prior to retaining and/or sharing savings, the CMO must achieve and maintain its Minimum Balance in the cash reserve account as verified both by the year end independent financial audit and reports from the depository organization in which the cash reserve is deposited.

   a. *Computation of Savings.* For purposes of this provision, savings are defined as excess CMO Revenues over expenses. The savings will be determined by an independent financial audit that is based on the CMO's financial reports required under Article X, *Reports and Data* (page 72) of this contract.

   b. *Savings to be Shared.* At the end of this contract period, The CMO shall first place all savings, up to a maximum of 15% of revenues, in a segregated cash reserve account before sharing savings with the Department. The CMO will share savings to the same extent that it will share losses under sec. C.(1)(b), above.

   c. *CMO Use of Savings.* The CMO may use its retained share of savings for any purpose and at its sole discretion, except for the funds placed in a segregated cash reserve account pursuant to subsection b., above.

Department of Health and Family Services Arrangement for Sharing Loss and Savings			
Loss (Savings) Corridors	**Share of Loss (Savings)**		
	CMO	**State**	**Federal**
< 2%	< 100%	0%	0%
2% to 10%	50% of non-federal share	50% of non-federal share	58.92% of federal share
> 10%	100%	0%	0%

IV. Reporting

Before the Effective Date of the Contract. Before the effective date of this contract the following documents must receive approval from the Department:

- Member Handbook, as described in Article II.B, *Member Handbook* (page 7).
- QA/QI Plan, as described in Article VI, *CMO Functions: Quality Assurance/Quality Improvement* (page 52).
- Subcontracts, as described in Article V.B(9), *Requirements for Subcontracts* (page 41).
- Adequate Service Coverage Plan, as described in Article V.B(7), *Before Effective Date of Contract* (page 40).
- Marketing/Outreach Plan and Materials (if any materials), as described in Article II.A, *Approval of Marketing/Outreach Plans and Materials* (page 6).
- Prevention and Wellness Plan as described in Article III.D, *Prevention and Wellness* (page 30).
- Business Plan, which includes monthly budget, revenue and enrollment projections, as described in Article VII.A(2), *Business Plan* (page 58).
- Internal Complaint and Grievance process as described in Article IV, *Complaints and Grievance Procedures* (beginning on page 32).
- Self Directed Supports Plan as described in Article III.A(6)(b), *Self-Directed Supports* (page 18).
- Member Safety and Risk Policies, as described in Article I.E, *Member Safety and Risk* (page 6).
- Service Authorization Policies, as described in Article VI.E, *Authorization of Services and Utilization Management* (page 56).
- Template notification letter used to inform members of intention to reduce, delay, or terminate a current service, or to deny payment for a service, as described in Article IV.D, *Notice of CMO Intention* (page 33).

During the Course of This Contract. The dates in the following table assume a contract effective date of January 2000. The following table depicts the documents that must be submitted, the due dates and other information:

Due Date	Type of Report	Reporting Period	Reference
Within 15 days of beginning of contract period	Civil Rights Compliance Action Plan (if not on file with the Department)	Contract Period	Article VII.E
Within 30 days of beginning of contract period	Cash Reserve Investment Plan (if planning to place in an investment account)	Contract Period	Addendum III
March 1, 2000	Client Specific Data	January 2000	Article X
April 1, 2000	Client Specific Data	February 2000	Article X
May 1, 2000	Client Specific Data	March 2000	Article X
May 1, 2000	Status of Cash Reserve Account	January through March, 2000	Addendum III(B)(5)
May 1, 2000	Narrative Report	January through March, 2000	Article X
May 1, 2000	Financial Report	January through March, 2000	Article X
May 1, 2000	Third Party Liability	January through March, 2000	Article IX, Addendum V
June 1, 2000	Client Specific Data	April 2000	Article X
July 1, 2000	Client Specific Data	May 2000	Article X
July 1, 2000	Separation Plan	Contract Period	Article I
August 1, 2000	Client Specific Data	June 2000	Article X
August 1, 2000	Status of Cash Reserve Account	April through June, 2000	Addendum III(B)(5)
August 1, 2000	Narrative Report	April through June, 2000	Article X
August 1, 2000	Financial Report	April through June, 2000	Article X
August 1, 2000	Third Party Liability	April through June, 2000	Article IX, Addendum V
September 1, 2000	Client Specific Data	July 2000	Article X
October 1, 2000	Client Specific Data	August 2000	Article X
November 1, 2000	Client Specific Data	September 2000	Article X
November 1, 2000	Status of Cash Reserve Account	July through September, 2000	Addendum III(B)(5)
November 1, 2000	Narrative Report	July through September, 2000	Article X

Due Date	Type of Report	Reporting Period	Reference
November 1, 2000	Financial Report	July through September, 2000	Article X
November 1, 2000	Third Party Liability	July through September, 2000	Article IX, Addendum V
November 1, 2000	Assessment of Self-Directed Supports Plan	January through September, 2000	Article III
December 1, 2000	Client Specific Data	October 2000	Article X
January 1, 2001	Client Specific Data	November 2000	Article X
February 1, 2001	Client Specific Data	December 2000	Article X
February 1, 2001	Status of Cash Reserve Account	October through December, 2000	Addendum III(B)(5)
February 1, 2001	Narrative Report	October through December, 2000	Article X
February 1, 2001	Financial Report	October through December, 2000	Article X
February 1, 2001	Third Party Liability	October through December, 2000	Article IX, Addendum V
February 1, 2001	Complaint and Grievance Report	January through December 2000	Article IV
June 1, 2001	Annual Audit	prior calendar year	Article VII

The CMO shall submit all reports according to reporting periods on due dates indicated in this Addendum to the Department:

Department of Health and Family Services
CDSD-Contracts Section
One South Pinckney Street, Suite 340
P.O. Box 1379
Madison, WI 53701-1379

Prior to Future Contract Renewals. Before the effective date of future Health and Community Supports contracts, the following documents must receive approval from the Department:

- Marketing/outreach plan, as described in Article II.A, *Approval of Marketing/Outreach Plans and Materials* (page 6).
- Affidavit of Subcontracts, as described in Article V.B(9), *Requirements for Subcontracts* (page 41).
- Enrollment Plan, as described in Article VII.A(2)(a), *Business Plan* (page 58).
- Adequate Service Coverage Plan as described in Article V.B(7), *Before Effective Date of Contract* (page 40).

V. Third Party Liability (TPL) Report Format

State of Wisconsin Medicaid the CMO Report on Third Party Liability

Name of the CMO:_____

Mailing Address:_____

Office Telephone:_____

Provider Number:_____

Please designate below the quarter period for which information is given in this report.

_____, 19_____ through _____, 19_____

INSTRUCTIONS

For the purposes of this report, a member is any individual listed on the monthly enrollment reports coming from EDS.

Casualty recovery may include collections from auto, homeowners, or malpractice insurance, as well as restitution payments from the Division of Corrections, and by uninsured motorists. In addition, casualty recoveries should include collections from Workers' Compensation. Casualty recovery as such is defined as collections resulting from liabilities arising out of any kind of personal injury, whether in tort or Workers' Compensation. Examples of tort claims would include auto accidents, slip and fall, defective products, or medical and legal malpractice.

Birth costs are not a third party right, and consequently are not included in this report.

Third Party Liability (TPL) Reports are to be completed on a calendar quarterly basis.

Please complete and return this report within 30 days of the end of the quarter being reported to:
Department of Health and Family Services
CDSD-Contracts Section
One South Pinckney Street, Suite 340
P.O. Box 1379
Madison, WI 53701-1379

Attn: TPL Report from _____ CMO

Third Party Liability (TPL) Report

Private Health Insurance

1. Dollar Amount Billed_____
2. Dollar Amount Collected or Avoided_____
3. Number of Members Involved_____
4. Total Number of Insured Members_____

Medicare

5. Dollar Amount Billed_____
6. Dollar Amount Collected or Avoided_____
7. Number of Medicare Members_____

Casualty

8. Accounts Receivable, End of Period_____
9. Dollar Amount Recovered or Avoided_____
10. Total Cases Settled_____
11. Total Settlements with Compromise_____
12. Dollar Amount Compromised_____

I HEREBY CERTIFY that to the best of my knowledge and belief, the information contained in this report is a correct and complete statement prepared from the records of the CMO, except as noted in the report.

Signed_____
Original Signature of Director or Administrator

Title_____ Date_____

VI. Actuarial Basis

The per member per month payment rates for this contract were developed by the Department with assistance from Milliman and Robertson, Inc., Actuaries and Consultants. The rates were developed by defining an actuarially equivalent comparable group, identifying the services to be included in the per member per month payment, and accessing paid claims and reported service cost data from two Departmental information systems, as outlined in (A) through (C) below. Further detail on the development of these per member per month payment rates can be obtained by consulting the Department's Final Rate Setting Report.

A. Medical Status Codes Used to Identify Comparable Population

Criteria to identify the comparable population were Home and Community Based Waiver eligibility in 1998 and the following Medical Status Codes:

Target Group – Location of Service	Medical Status Codes
Aged – Nursing Home	3,6,9,L8
Aged – Non-Nursing Home	1,2,4,5,AD
Disabled – Nursing Home	6C,6D,7,13,16,17,25,26,28,40,41,42,48,49, 50,52,DN,L2,L4,L6,QN
Disabled – Non-Nursing Home	5C,5D,10,11,12,14,15,19,21,22,23,24,BD, DC,DD,L1,L3,L5,L7,QR,W2,WA,WB,WC, WI,WW

B. Data Sources for Services in Per Member Per Month Payment

The per member per month payment rates are based on historical costs of all services in the benefit package. The data sources for the paid claims and reported service cost data include:

- All 1998 COP and Home and Community Based Waiver services as reported on the Long Term Support module of HSRS; and
- Paid claims data for services in the LTC benefit package from the 1998 Medicaid Management Information System (MMIS).

C. Per Member Per Month Payment Rates

1. *Comprehensive Level of Care Per Member Per Month Payment Rate*.

Base Rate: _____
Lag Adjustment Factor: _____
Data Adjustments: _____
Trend Rate & Acuity Factor: _____
Administrative Cost Adjustment: _____
Managed Care Discount: _____
Final Prospective Rate: _____

2. *Intermediate Level of Care Per Member Per Month Payment Rate*.

   Base Rate: _____
   Lag Adjustment Factor _____
   Data Adjustments: _____
   Trend Rate & Acuity Factor: _____
   Administrative Cost Adjustment: _____
   Managed Care Discount: _____
   Final Prospective Rate: _____

3. *Prospective Rates.* Note that the preliminary per member per month payment rates reported in the two tables above are the prospective rates to be paid to a given CMO for enrolling a member at a given level of care. The level of care is determined by the LTC Functional Screen and the COP Functional Screen which is completed by the Resource Center.

VII. Medicaid CMO Personal Injury Settlements

CMO Name: _____

Name of Recipient and MA ID Number	Date TPL Payment Received	If Available		Payer
		Attorney Name	Amt. Received	
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				

Mail this Form to:
Department of Health and Family Services
CDSD-Contracts Section
One South Pinckney Street, Suite 340
P.O. Box 1379
Madison, WI 53701-1379

VIII. Performance Improvement Projects

PART 1: Performance Improvement Projects

A. Overview

The main purpose of a Performance Improvement Project is to improve outcomes for the CMO membership overall or a group of members who have similar care and service needs.

Part 2 of this Addendum specifies certain focus areas and member outcomes to be addressed by Performance Improvement Projects. A project shall be based on one of the three focus areas: 1) self-determination and choice, 2) community integration, or 3) health and safety, and on at least one member outcome within the chosen focus area. Within the chosen focus area and outcome, the CMO shall develop specific measurable outcome indicators that will assist in measuring progress towards improving the broad outcome. The focus areas and outcomes are listed in this Addendum under *"Part 2: Performance Improvement Project Options."*

- Multiple Focus Areas
  A single Performance Improvement Project may address more than one focus area or more than one outcome, as long as the Performance Improvement Project meets the requirements listed in section (B) below for each focus area and/or outcome selected.

- Alternative Focus Areas or Outcomes
  If the CMO desires to choose a Performance Improvement Project outside of the options provided *in "PART 2: Performance Improvement PROJECT OPTIONS,"* the CMO shall submit the request to the Department for review and approval.

- Collaborative Performance Improvement Projects
  CMOs may satisfy the requirements of this Addendum by participating in collaborative Performance Improvement Projects in conjunction with one or more CMOs.

- Other Projects.
  In addition to the required project specified above:

  a. The CMO may initiate its own Performance Improvement Projects, and
  b. The Department may require that the CMO:
     - Conduct particular performance improvement projects that are specific to the CMO; and
     - Participate annually in at least one statewide QA/QI effort.

c. Performance Improvement Projects: Schedule

1. The following is the required timeline for the annual Performance Improvement Projects:

   a. By the end of 2000:
      - The CMO shall initiate one Performance Improvement Project (see steps "a-f" in section C below). The CMO's chosen Performance Improvement Project shall come from one of the three different focus areas listed under *" Part 2: CMO Performance Improvement Project Options."*

   b. By the end of 2001:
      - The CMO shall demonstrate improvement in the project initiated by the end of 2000 (see steps "g" and "h" in subpart c below.;
      - The CMO shall complete one additional Performance Improvement Project that is not an extension of the project conducted in the year 2000.

C. Performance Improvement Projects: Components

1. The following components are required of every Performance Improvement Project. The CMO should include these components when designing, implementing, and evaluating a project. The Department will use these components to assess and evaluate projects conducted by CMOs.

   a. *Topic*: A topic that is a relevant area of concern or an area of desired improvement for the CMO. The topic shall meet the following criteria:
      - The selected topic should affect a substantial portion of the CMO's members (or a specified sub-group of members) and be related to one of the focus areas and an outcome within a focus area listed in Part 2 of this Addendum.
      - The CMO may select a topic that focuses on conditions or services that occur less frequently in the membership, if there is a pattern of unexpected, adverse outcomes for the condition or service selected.
      - However, the prevalence of a condition or volume of services involved should be sufficient to permit meaningful study.
      - The CMO should select topics that need improvement either because there is significant variation in processes and outcomes within the CMO or the CMO's performance as a whole falls below acceptable benchmarks or norms.
      - Topics should focus on areas that the CMO could change to get better results or outcomes for members.
      - The CMO's providers shall have a formal opportunity to participate in the selection and prioritization of projects.

b. *Target Population*: A defined target population that includes all members who are involved in the aspect of care or services under the topic.
- Sampling is acceptable as long as the CMO ensures that individuals included in the samples are randomly assigned and the size is statistically valid.

c. *Purpose*: The aim or purpose of the project, i.e., the purpose statement should explain the reason for selecting the chosen topic, what interventions are to be improved, and intended improvements in results or member outcomes.

d. *Quality Indicators*: Defined objective quality indicators or measures that assist the project team in monitoring processes and outcomes of care and services for the target population. Quality indicators help the CMO measure progress towards goals. For each project, the CMO shall assess its performance using quality indicators that are:

- Capable of measuring outcomes such as changes in health status, functional status, and enrollee satisfaction with CMO services, or measuring processes that are associated with outcomes. Examples of indicators are the presence or absence of symptoms, perceived quality of life, perceived quality of care, physical functioning, social role functioning, side effects of treatments, or prevention.
- Measures of processes are used as a proxy for outcomes only when those processes relate significantly to outcomes.

e. *Data Collection Plan*: A data collection and analysis plan for determining CMO performance on quality indicators.
- The CMO shall take steps to ensure that data are uniformly extracted and recorded.

f. *Data Interpretation*: A summary and an interpretation of the findings, including a description of barriers or gaps in performance and/or improvement opportunities that have been identified from the analysis of the data.

g. *Improvement Plan*: A plan to improve care and services for the defined target population including:
- Descriptions and an analysis of the specific process steps that are currently in place for delivering care and services to the defined target population
- Specific interventions, identification of persons responsible for the interventions, timelines, and a description of how and when the project's effectiveness will be measured.
- The CMO's interventions shall aim at achieving improvement that is significant and sustained over time.
- A CMO demonstrates significant improvement when it achieves a benchmark level of performance that is defined in advance; or it achieves an increase in the percentage of members who achieve the desired outcome defined by the indicator.

- Sustained improvement is demonstrated when the CMO shows through continued measurement that its performance gains have endured for at least one year.

h. *Evaluation*: A review and evaluation of whether or not the new interventions were effective in achieving the desired outcome(s).
   - Once the improvement plans have been initiated, data shall be monitored over time for change.

2. The CMO shall report the status and results of each project to the Department upon request. The report shall include the following:
   a. The topic and the reason the CMO selected the project topic;
   b. A description of the population or sub-population and the sampling methods used if applicable;
   c. A description of the aim or purpose of the project;
   d. The specific quality indicators used to measure CMO performance and how they relate to one or more member outcomes defined in Part 2 of this Addendum;
   e. A description of the data collection methods used and the procedures through which the CMO has assured that the data are valid and reliable;
   f. A summary of the findings based on the analysis and interpretation of the data;
   g. Documentation of the system interventions which were implemented to improve performance;
   h. The results of the CMO's Performance Improvement Projects. Specifically, whether or not the CMO:
      - Achieved a level of performance that exceeded its own baseline performance; or
      - Measured a percent improvement in outcomes for the selected indicator(s).

Part 2: CMO Performance Improvement Project Options

Focus Area #1: Self-Determination and Choice
The CMO may choose one of the following member defined outcomes in this category.

Outcome: Members are treated fairly.
Outcome: Members have privacy.
Outcome: Members have personal dignity and respect.
Outcome: Members choose their services.
Outcome: Members choose their daily routine.
Outcome: Members achieve their employment objectives.

Focus Area #2: Community Integration
CMOs may choose one of the following member defined outcomes in the community integration focus area:

Outcome: Members choose where and with whom they live.
Outcome: Members participate in the life of the community.
Outcome: Members remain connected to informal support networks.

Focus Area #3: Health and Safety
CMOs may choose one of the following member defined outcomes in the health and safety focus area:

Outcome: Members are free from abuse and neglect.
Outcome: Members have the best possible health.
Outcome: Members are safe.
Outcome: Members experience continuity and security.